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ABSTRACT

This issue of Emphasis addresses the educator's role in confronting adolescent pregnancy by presenting articles on educational programs for adolescents which have been developed and/or implemented by Planned Parenthood affiliates. Programs are presented which attempt to provide information to adolescents or to the community; to change attitudes, such as changing young men's attitudes about responsibility for contraception; or to change behavior. Articles include: (1) "In Perspective" (Susan Newcomer)--people and programs in sexuality education; (2) "A Center for Change" (Sally Kohn and Pat Maloney)--an inner city teen pregnancy prevention program; (3) "Males: A New Market" (Joanne Rocco Bruno)--Planned Parenthood programs for men; (4) "Panel for Prevention" (Pat Lyden)--views on delaying sexual activity and using contraceptives responsibly; (5) "The Case for Counseling" (Ellen Taves) emphasizes personal history and relevant choices in the counseling process; (6) "A Community of Volunteers" (Margo Mills-Smith)--teen outreach program; (7) "Progress for Peers" (Cindy J. Biggs)--an Ohio Community-implemented high school education program; (8) "Close-Up: Doug Kirby" (Michael McGee)--an interview with the director of research at the Center for Population Options; (9) "The Clinic Connection" (Marcia Aslakson) describes a Michigan school-based teen health clinic; (10) "Accent on...Electronic Sexuality" tells of a Milwaukee forum that addressed the question of whether teen sexual attitudes and behavior are influenced by music; (11) "Humboldt Heralds FLE" (Randy Crutcher) focuses on a family life education (FLE) program in California; (12) "How to Say No" (Patricia Brogan and Patti O. Britton) provides teens with the skills to say no to undesired sexual intercourse; (13) "A Cornucopia of Care" (Cathy Ahart) describes a program for helping teens and their families with practical support; (14) "Dallas Drama in Demand" (Elena Love) tells of a Texas teen theater troupe that improvises skits dealing with problems of peer pressure and teen pregnancy; and (15) "Courting Challenge" (Jaxie Farrell) discusses a Washington program taught jointly by Planned Parenthood and the Walla Walla office of Juvenile Court Services. A 25-page annotated bibliography dealing with topics such as sexuality education, contraception, parenthood, and reproductive health is appended. (NB)

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Education Department

Winter 1985-86



Emphasis

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Emphasis

Highlighting people and programs in the field of sexuality and population education.

Planned Parenthood Federation of America, Inc.

FROM THE EDITORS

This issue of *Emphasis* examines the many kinds of educational programs serving teenagers today. We have taken a special look at several of the varied methods that Planned Parenthood affiliates have used to attract teens into programs and to create services that teens really use. We hope this information will assist you in your work—to prompt you to investigate new approaches or to contact the authors for their suggestions in leading you in new directions.

Our next issue will focus on what is new in the expanding area of religious organizations' involvement in sexuality/family life education. Even though we produced a similar issue on this relevant topic in 1983, there has been such interest and growth in this arena that it warrants an update. Addressing the relationship between religion and family life education is a marvelous way to enrich programming at both the local and national levels and to forge harmonious partnerships between sexuality educators and religious leaders. We know that this will be an inspiration and impetus for your future program plans.

We encourage you, as always, to send us your feedback about how *Emphasis* assists you. To help you do that, we are enclosing a brief questionnaire. Please take the time to complete it and mail it back to us by April 1. We will then be able to integrate your suggestions into our publication design and make *Emphasis* an even more timely and suitable asset to the field.

The Editors

Patti, Mike and Linda

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In Perspective

One of the Federation's five-year goals is "to reduce adolescent pregnancy and unwanted births to teens." Obviously, Planned Parenthood is concerned about the high rates of pregnancy among U.S. teenagers, and about the generally grim futures that very young parents often face. This issue of *Emphasis* addresses the educator's role in confronting adolescent pregnancy by presenting articles on educational programs which have been developed and/or implemented by Planned Parenthood affiliates for teenagers. In April of 1986 there will be an issue of *Planned Parenthood Review* which will look at other Planned Parenthood programs for adolescents.

Many communities have recently begun teenage pregnancy prevention programs because they are concerned with the particularly high rates of teenage childbearing in their areas. Other communities have initiated teenage parenting programs, concerned with the limited capabilities of many teen parents. All such "secondary prevention" programs should, we hope, also include the provision of birth control as a component of their services. The trigger for such teen programs, be they "primary" or "secondary" prevention, is often the realization that local teen pregnancy or abortion rates are particularly high. The real issue is a national one: the very existence of unintended adolescent pregnancies. This is a nationwide social crisis in which young people are not being helped to develop responsible sexual behavior.

One of the major lessons I learned from the AGI study of teenagers in European countries is that community attitudes and practices have an important bearing on the behaviors of young people. Where one's sexuality is recognized as a natural part of human existence, not as something immoral to be banned, or as a come-on to be used to sell commodities, young people seem to accept their sexuality, and to be effective contraceptors when they have intercourse. In the United States, however, adolescents have a difficult time developing healthy sexuality partly because of the conflicting messages about sex that are ever-present in our society.

Planned Parenthood, as the oldest and largest family planning agency in the country, has, and will continue to have, a key role in the community "climate-setting" about sexuality. Though we certainly cannot, all by ourselves, stop children from having children, we can continue to provide the kinds of education which inform choice. With our advocacy and our excellent programming, we assist in slowly changing community attitudes. In practice, this is most

effective when "consciousness-raising" is coupled with our taking an assertive stand on the issue. Increasing information, changing attitudes, and access to contraceptive services will lead, over time, to changed behavior. In this case, the goal of the changed behavior is a drop in the likelihood of a young person's becoming a parent before he or she becomes an adult.

The variety of teen programs presented here demonstrates many approaches to these three aspects of change. We describe programs which have as their goal providing information to teens or to the whole community. There are programs which set about changing attitudes, such as changing young men's attitudes about responsibility for contraception. There are programs, such as school-based clinics, which directly aim to change behavior. All three are important components of an integrated approach to a very large challenge. If we are to take responsibility for meeting this challenge, we must confront the illusion that our society is supporting young people to delay parenthood. As a famous man once wrote, "We must not simply change people's illusions, we must change the conditions which cause the illusions."

Susan Newcomer, Ph.D.
Director of Education

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CONFLICT AND CHALLENGE

THE PEER PERSPECTIVE

THE FAMILY

A Center for Change

This inner city, comprehensive teen facility shines as a new model in pregnancy prevention.

by Sally Kohn and Pat Maloney

The Hub, A Center For Change For South Bronx Teens, is a pregnancy prevention program co-sponsored by Planned Parenthood of New York City and the Bronx-Lebanon Hospital Center. A grant from the Robert Wood Johnson Foundation's Program To Consolidate Health Services For High-Risk Young People helped to launch the Hub in 1982.

The Hub is located in the poorest congressional district in the country. One out of four babies born to South Bronx residents has a teen mother, and four out of five teen mothers were themselves born to teens. The rate of pregnancy in the Bronx for women 15 to 19 is 142.9 per 1,000, the highest of any county in New York State.

The Hub is located in an attractive, newly renovated two-story facility in an office building in the commercial area of the South Bronx. In 1985 the Hub served over 3,000 teenagers in its facility, and through public education programs for parents and teens, over 8,000 community residents were served.

The program was developed under the leadership of the project director, Sally Kohn, who joined the staff in 1982. A management committee consisting of senior staff from Bronx-Lebanon Hospital and from Planned Parenthood of New York City has set the program's course and monitored its development. Over forty full-time employees staff the program which is open six days a week, Monday through Saturday, and four evenings until 7:00 p.m.

A different approach

The Hub is unique in many respects. First and foremost, its comprehensive approach to serving adolescents at high risk of pregnancy and childbearing is based upon the core philosophy that teenagers must be presented with attractive and attainable alternatives to premature parenting. Experience has shown that family planning services and information alone are not enough to persuade young people, particularly those from areas of poverty like the South Bronx, that life options exist beyond childbearing, dropping out of school or unemployment.

Therefore, *all* of the Hub's programs seek to strengthen the self-esteem and individual development of both male and female teens. Specifically:

►Health services are provided by three teams, each consisting of a medical provider and a social worker, who specialize in working with adolescents. This structure ensures continuity

of care, individual attention to the client, and a system for follow-up which is critical when dealing with teenagers. Referrals to the Hub's other programs are frequently made through these health and social service providers, and various problems are identified and appropriately referred for treatment.

►The Learning Center, staffed by two male counselors, performs educational assessments, referrals, counseling, computer and job readiness training, and a successful peer tutoring program which has resulted in raising the reading and math levels of participants by two grades. Over half the teens registered with the Learning Center are males, reflecting staff's assertive outreach efforts.

►Recreational programs are crucial to attracting both boys and girls, and are directly related to their health services as each registered adolescent is required to have a complete physical exam—which includes family planning counseling—before participation. Classes in karate, aerobics, arts and crafts, jazz dance and modeling (a popular option for increasing self-esteem) draw dozens of teens to the Hub every afternoon. The classes are also a source of social comfort which helps young teens develop relationships with their peers.



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►Contraceptive rap groups, led by trained staff, are held twice a week and are mandatory for all first-time family planning visitors. Male partners are encouraged to attend.

►Community education is provided for parents and teens on human sexuality and improving communication between generations.

Public policy

Beyond its walls, the Hub has translated its hands-on experience to change policies which currently reinforce the patterns of teenage pregnancy and parenthood. The media have used the Hub as a major resource on teen issues, further influencing the way the public perceives adolescent childbearing. Public policy efforts have included:

►A congressional hearing on-site in 1984, chaired by three members of New York City's congressional delegation, focused on the issue of teenage pregnancy. This highly publicized event featured testimony by teens themselves, key elected officials (the mayor, city council president and comptroller), and a variety of community agencies and concerned individuals. As a result, Congressman Robert Garcia (D-Bronx) introduced federal legislation (H.R. 947) that would implement a preventive strategy to address teen pregnancy at the national level.

►Following visits to the Hub and meetings with staff and board, Governor Mario Cuomo's office developed a \$5 million pregnancy prevention initiative (in 1985) which will fund programs designed to meet high-risk community needs. The Hub was part of a coordinated multi-agency collaboration in the Bronx which applied for and received the maximum level of funding (\$450,000) to support teen pregnancy prevention programs in our country. New York's legislation provides a model for other states that are moving to address this same issue.

►Citywide attention on teen childbearing has increased as a result of their direct endeavors to work closely with a special Mayoral Office of Adolescent Pregnancy and Parenting Services. An inter-agency policy committee formed to develop strategies for the coordination of youth services. Changes in Medicaid procedures and training enable pregnant teenagers to receive medical assistance in a confidential and timely fashion.

►A widely-attended community forum was held at the Hub to discuss preventive strategies for decreasing the school drop-out rate. Currently, only three of every ten ninth graders in the South Bronx will actually graduate from high school.

The community's response to the Hub has been very positive. Adolescents themselves, aged 10-19, have increasingly sought the Hub's services and joined its programs. Parents are encouraged to visit and are regularly invited to special events and registration sessions. Other people from the community—clergy, educators, health and social service providers, policymakers and elected officials—frequently come to see the Hub and learn about its approach. (This is also true for many out-of-town and out-of-state visitors.)



Teens from the HUB testifying at a congressional hearing on teen pregnancy.

Patient data shows a continuing increase in the number of teens coming and returning to the Hub for services, and notably so for males. The number of medical visits to the center went from 9,000 in 1982 to 12,000 in 1984, nearly a one-third increase in two years. The greatest increase came from visits by teenaged clients. For the 15-to-19-year old age group, between 1983-84, the number of medical visits rose a total of 24%, while the number of clients under 15—a group targeted for special outreach—went up 40.6%.

A follow-up system is employed now by their health care providers, and will soon be followed by the Learning Center and recreational programs, to document what happens to the teen clients after their initial involvement at the Hub.

The Hub demonstrates that two institutions with a shared concern for high-risk young people

can make a difference—for the clients directly reached by new and expanded services—for the community residents who use the Hub's resources—and for the public officials and policymakers who, along with the Hub staff, learn from young people about the many ways in which policies and programs need to respond better to their everyday concerns. ■

Sally Kohn, M.P.H., has been the Hub's Program Director since it was initially developed in 1982. She is an Assistant Professor of Epidemiology and Social Medicine at the Albert Einstein College of Medicine. Pat Maloney is Administrative Coordinator of the Hub and has worked on city policies affecting youth. For more information contact: The Hub, 349 E. 149th Street, Bronx, NY 10451.

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HAVING A BABY?

thehub is your place to get the care you need

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- Career counseling and planning for child care

149 Street Uptown

Males: A New Market

By changing its "women-only" image with a catchy publicity campaign, this PP included males in its services.

by Joanne Rocco Bruno

Since the 1970's Planned Parenthood Southeastern Pennsylvania (PPSP) has envisioned incorporating services for men. Long-range plans and a 1979 needs assessment of potential consumers (males 10-50 years of age) reflected both staff hopes and real community interest. The idea made philosophical sense to the staff, who believed that Planned Parenthood's "women-only" public image perpetuated the myth that reproductive health care and pregnancy decisions are "women-only" issues.

In fact, PPSP had always provided some form of male services. Hundreds of their community education and professional training participants were male. Clinicians treating women for STDs often issued a prescription or referral for male partners. So service to males was hardly new. The real innovation was explicitly acknowledging the agency's commitment to males by expanding and altering PPSP's community image.

When a local foundation became interested in supporting a new initiative, the Education and Development Departments reviewed their research with five other Planned Parenthoods serving males in metropolitan areas, one hospital-based program in Philadelphia, and the agency's needs assessment which surveyed 600 teen/adult males. Their conclusions were:

- ▶ Males of all ages are *most likely* to come to a clinic for STD screening and treatment.
- ▶ Males are generally crisis-oriented regarding their own health care.
- ▶ Initial STD screening entry can provide a mechanism for education about family planning and reproductive health care concerns.
- ▶ Older teens/young adults (17-29) are more likely to respond to medical services.
- ▶ Pre-teens/younger teens (10-16) need to be reached through schools and community organizations.
- ▶ Although generally a "slow-starter," male services programming can succeed with adequate promotion, charismatic male staff and sufficient time to alter the public image of Planned Parenthood as "women-only."

With the agency's needs as well as grant criteria in mind, staff drafted a program proposal which would aggressively reach out to the target group. Original plans included hiring three staff members (clinician, educator and outreach worker), preferably all male, who would offer medical/counseling services at three sites and provide educational programs in the community. A marketing campaign would augment the efforts of the outreach worker. Ad-

ditional funding would depend on in-kind contributions from local advertising firms to help contain costs.

The foundation responded generously and enthusiastically, providing the funding for what would eventually be known as Project MARCH (Men Acting Responsibly for Contraception and Health).

An unexpected obstacle confronted the project in the first month of planning: they could not find a suitable male clinician and only one candidate emerged with appropriate qualifications for either the educator or outreach positions. Luckily, PPSP was fortunate to have a female clinician on staff with extensive prior experience in working with males and a strong background in STDs. She was extremely interested in the project, did not perceive her gender as a barrier to service and agreed to be the primary clinician, saving the day for the male services medical component. Following the old adage, "Use what you got to get what you need," PPSP immediately hired the qualified male candidate as a combination educator/outreach worker.

Delays

With "Planned Parenthood is for Males, Too!" as a slogan, the staff developed brochures, public transit car cards, flyers and wallet cards. This led to obstacle number two: "in-kind" printing/advertising almost never means "on-time." The publicity plan was delayed, but undaunted, the educator/outreach staff member persisted. The male services project was underway.

Despite the slower-than-expected first year start (it took four months just to hire staff), PPSP reached 850 males. One hundred forty-five men, most of whom were in their 20s, accounted for 195 patient visits, and 705 adolescents participated in educational programs. Despite the problems, it was an encouraging beginning.

Foundation support remained firm for a modified second-year grant, and the first year's experience led to an alteration of program priorities. The original goal of "educating males about their role and responsibilities in family planning, reproductive health and sexual relationships" was retained—but now, public awareness/community education was primary while medical services became secondary.

Project staff learned that the medical component was attracting a much older population than anticipated; adolescent males seemed even



Emphasis

Panel for Prevention

This teen panel proves to be an effective and moving vehicle for changing attitudes in Cleveland schools.

by Pat Lyden

Cleveland, Ohio has one of the highest rates of teenage pregnancy among major cities in the country. Planned Parenthood of Greater Cleveland's (PPGC) training and education department seeks to address this problem by promoting sexual responsibility. In the fall of 1983, the agency launched its Teenage Pregnancy Prevention Panel. Modeled after a similar program conceived by the Planned Parenthood affiliate in Toledo, the panel had a two-part message. The main message was, "Say no to sexual involvement as a teen," and the secondary message was, "If you're already sexually active, use birth control to prevent an unwanted pregnancy."

The panel was comprised of teenage mothers and fathers, parents of teenage parents, and young women who have chosen either abortion or adoption. Panel members presented both the viewpoints of delaying sexual activity and using contraceptives responsibly.

These young people were recruited through job descriptions posted in youth serving agencies and community colleges, and referrals from cooperating agencies. Planning and supervision of the project was done by the Director of Training and Education and a full-time community educator who served as Panel Coordinator.

Panel structure

There were two parts to the program: the panel presentation itself and a follow-up education session. Panels were conducted in the Cleveland public schools at the secondary level; most of the sessions were held in junior high schools, because it was decided that the panel would have greater preventive impact on this age group.

The Panel Coordinator scheduled the five or six panelists and made all arrangements with the schools, where special 90-minute assemblies of 200 students were held in the auditorium. The three-part format was as follows: 1) an overhead projector presentation summarizing teenage pregnancy and its consequences, 2) the personal stories and messages of the panelists, and 3) a question-and-answer session.

Cleveland Public Schools students are Black (70%), white (25%), and Hispanic (5%), and the panel reflected this racial mix. Staff quickly learned that without at least one teenage father at each presentation, the male members of the audience could feel left out and be disruptive. The fathers were the most difficult panelists to recruit.

One week after the panel presentation, the

coordinator conducted follow-up education in small group sessions. Students were encouraged to talk about their reactions to the panel, and then sexual decision-making and birth control methods were presented.

The most essential component of the program was the panelists' sharing their personal histories. Students really listened to the details of the panelists' lives. At times the presentations were very emotional, and tears were not uncommon. PPGC found the real-life drama of peer education to be a very successful mechanism for imparting their message.

Each student received a Teen Lives packet of printed materials which consisted of a Planned Parenthood wallet-size service card, "Teen Sex: It's OK to Say No Way," "NO and Other Methods of Birth Control," and "Problem Pregnancy Alternatives."

In two school years over 10,000 secondary students were served by the project, most of whom were in the seventh or eighth grade. Student and teacher feedback was overwhelmingly positive. Pre- and post-testing was done to determine if attitudes were changed as a result of the Teen Panel experience. There were significant attitudinal changes, particularly among the males, in favor of abstinence and birth control use.

In March of 1985, the project won the prestigious Anisfield-Wolf Memorial Award for outstanding service to the Greater Cleveland community. Even though the project was deemed successful, PPGC decided to phase it out in the summer of 1985. It was determined that prevention efforts would be more successful with upper elementary students. Hence, the training and education department launched the "Postponing Sexual Involvement" series, developed by Dr. Marion Howard, in sixth grade classrooms. ■

Pat Lyden is Director of Training and Education for Planned Parenthood of Greater Cleveland. For more information, contact PPGC, 1501 Euclid Avenue, Suite 300, Cleveland, OH 44115.



The Case for Counseling

This PP emphasizes personal history and relevant choices in their counseling process.

by Ellen Taves

"What did you come to Planned Parenthood for?" "A pregnancy test. I'm two weeks late for my period." The counselor says, "Tell me what's been going on." This focuses the interview on the past, on what led the girl to be in this situation. "My boyfriend and I are planning to get married when we finish high school. But I didn't want to be pregnant now. We weren't using anything. He said he'd pull out, but about half the time he forgot."

This client presents a contradiction. She said she didn't want to be pregnant and yet she persisted in using a method that obviously wasn't working for her. To help her understand the problem, the counselor might explore with the client her relationship with her partner, family and friends; and her beliefs about sex, birth control, marriage and pregnancy.

This illustrates a typical interview in the counseling department of Planned Parenthood of Rochester and Monroe County (PPRMC). Clients come to PPRMC for help in looking not only at "where to go from here," but, more importantly, "how they got here": the feelings, beliefs, fantasies, values, behaviors, and attitudes about themselves and others that led them to have the problem in the first place. All clients who come in for a pregnancy test, not just those who are pregnant, are seen by a counselor. Unless the pregnancy is planned, the situation that led the client to risk pregnancy is the same whether the result is positive or negative. The PPRMC staff believe that very few people are truly ignorant of issues relating to sex, birth control and pregnancy, and their primary need is for help in looking at what made it difficult for them to use the information they have to prevent problems from arising.

The PPRMC counseling staff see about 8,000 clients per year for a variety of sex and fertility concerns. Most clients talk to volunteer counselors trained by department staff. The department offers two training programs: New Counselor Training, a 36-hour course devoted to interviewing, information, referral, and beginning counseling skills; and Advanced Counselor Training: a 21-hour course devoted exclusively to sharpening counseling skills. Throughout the training, Ellen Taves' book, *But Why Didn't She Use Birth Control?: A New Approach to Pregnancy Test Counseling*, is used as the text.

The counseling portion of the training consists of four areas:

►Basic counseling skills: These include reflecting feelings, reflecting thoughts, phras-

ing questions, and "pigtailing" (ways to encourage the client to explore more deeply the issues she is raising).

►Understanding client motivational concerns: they use Kristin Luker's book, *Taking Chances*, to understand what's going on with the individual, and readings on family systems theory to develop a framework for the interpersonal perspective. They believe that family systems theory helps counselors understand the primary social group within which the client functions and its impact on her behavior, even though the department counsels relatively few families.

►Helping counselors understand how their own feelings and thoughts about the client and her situation can adversely affect the interview: in class counselors interview each other about clients with whom they have problems. They learn techniques for helping each other explore and work through the feelings elicited by such clients. These feelings are a normal part of the counseling experience. Learning to recognize them and talk them through with another counselor will assure that over time they interfere less with the interview. The group views a film of a counseling session and analyzes how the counselor's own feelings about the client and her situation affected the outcome of the case.

►Case discussion: throughout the training, counselors present cases for discussion that they have found particularly satisfying or troublesome. In this way they learn to analyze what they are seeing in the interview and develop counseling strategies and goals appropriate for a particular client. They also come to realize that some clients are not interested in counseling or do not need to explore their situation. Others are not capable of such exploration. Some have such complex problems that the counselor can do little more than give them information and leave them feeling good about the time they spent at the agency. ■

Ellen Taves, M.S. Counseling, has been with Planned Parenthood for 10 years as the director of PPRMC's 45-member counseling staff. She is the author of Why Didn't She Use Birth Control? For more information, contact PPRMC at 24 Windsor Street, Rochester, NY 14605.

BUT WHY DIDN'T SHE USE BIRTH CONTROL?

A NEW APPROACH TO PREGNANCY TEST COUNSELING



by Ellen Taves
Director of Counseling

Planned Parenthood of Rochester & Monroe Co.
1981

A Community of Volunteers

Creative outreach methods and dedicated volunteers make possible this multi-faceted midwestern educational program.

by Margo Mills-Smith

Project: Decision was developed by Planned Parenthood of Central Indiana (PPCI) as a teen outreach program, to provide more extensive sexuality education to teens and parents in metropolitan Indianapolis. The project strives to help young people, and those who care for and work with them, to increase their comfort with discussing sexuality and acknowledge the importance of responsible decision-making in sexuality.

This teen outreach project was originally funded in 1982 as a two-year demonstration model by Lilly Endowment, a national foundation located in Indianapolis. The philosophy behind the name "Project: Decision" is based on the concept of involving the entire community in addressing the problem of teenage pregnancy. "Teens must decide whether or not to have sex, parents must decide whether they are going to talk to their children, and the community must decide whether or not to get involved." Therefore, Project: Decision is not just a program, but a concept and a total outreach effort.

Starting from scratch

Project: Decision began with very few guidelines beyond the goal of reaching 250 teens with education programs, and training 20 professionals in community agencies in the first year. A coordinator was hired in February of 1982 to "start from scratch." She felt she wanted to avoid the trap of spending hours developing innovative programs that adults think teens need, without listening to teens. Instead, with tape recorder in hand, she held meetings with teens in churches, 4-H clubs, schools, etc. to ask them what they felt was the most effective way of reaching teens. She asked the various groups, "Who talks to you about sexuality issues?" "Whom would you like to talk to?" "Would you participate in a theatre group or on a panel that portrays sexuality issues confronting teenagers?" The insights shown by the teens were enlightening and reaffirmed some of the things PPCI believed. For example, "I wish my parents would talk to me, but I want factual information from experts." Most said they would not go to see a theatre group but they would serve on a panel.

Following the teens' positive response during the needs assessment, it was decided to develop a panel to create another approach for reaching teens, parents, and adults. In 1983 the V.O.I.C.E.S. panel was created with the help of a committed volunteer. V.O.I.C.E.S. (Voicing

Our Ideas, Concerns, and Experiences About Sexuality) was composed of teens and young adults ages 16 through 21. These young people discussed personal experiences resulting from the sexual decisions they had made. There were eight members—three young men and five young women. They represented various voices: being sexually active, saying no to sex, being a teen parent, and choosing abortion. The only choice not represented was a teen who had decided on adoption. This panel made one-hour presentations, with time for sharing their experiences, and for audience questions. At the end of the year it was decided to re-structure the program, since it had become difficult to recruit new members.

The new panel, still called V.O.I.C.E.S., is composed of people from age 13 to adult. They discuss general issues related to adolescent sexuality and pregnancy, parent/teen communication, and related topics. The panel members are all volunteers, including the moderator. This new concept allows cross-generational discussion of the issues, and is very effective with parent/teen groups. It also allows teen audience members a chance to hear that adults often did not have role models for discussing sexuality issues when they were young.

Sharing the facts

Two of the volunteers on the panel were a mother and her teenage son. The mother commented in an article for the PPCI newsletter that "I learned the facts of life from my mother, and it took courage for her to tell the story. No one talked to her, and she grew up scared. She told me to ask her questions, but I didn't feel comfortable. That's why I think this panel is effective for people of my generation. We don't know how to deal very well with issues like teen pregnancy, peer pressure, or double standards. The panel gives us ideas on how to talk to our kids. We no longer assume the other's thoughts." Her son, David, stated "It's definitely more than a parent-child talk now. Mom and I are really getting to know each other as individuals." This panel exemplifies the positive results of honest and open exchange between the generations on the topic of sexuality.

Project: Decision programs are now fully integrated into the Community Education Department of Planned Parenthood in Indianapolis. Creative methods of teaching, developed to involve teens and adults, are being utilized in all of the agency's sexuality presentations and workshops. The guiding principle of communi-

ty outreach continues to influence other projects. The use of volunteers who not only have been trained to conduct educational programs, but also to serve as advocates for the agency, is an example. Another focus of Project: Decision was to reach more teen males. To do this, two male community professionals were recruited to help reach young men more effectively. When men co-facilitate with female staff, this helps teens see that men and women can discuss sexuality issues without it being labeled "sexy." One of the volunteers said that he wanted to raise men's consciousness because he feels that men who are in touch with their sexuality lead more meaningful lives. Actually, he contends, accepting responsibility for one's sexual behavior is in a man's self-interest.

The contributions the two men have made to the agency have been tremendous. Their involvement with Project: Decision led them to start a group called the "Concerned Males." It now exists as an autonomous group with a mission statement and goals. The group will be holding their second conference on male involvement this year.

Training others

In addition to these positive partnerships with

individuals, Project: Decision has provided training for the professional staffs of most of the city's community agencies. The director of a local pre-employment training program felt the training her staff received helped them feel more confident about issues of sexuality that they must deal with in the course of personal and career counseling. The training allowed them to sort out their own values enabling clients to make decisions for themselves.

These decision-making programs have also enabled PPCI to work with groups they had not previously reached. For example, a local Catholic church sought assistance from Project: Decision after hearing about it from a Protestant church. The coordinator and director of the department met with the nun responsible for education programs. After hearing that Project: Decision programs are individualized and based on the audience's needs, it was decided that although the philosophies of the Catholic Church and Planned Parenthood are different, the young people should not be deprived of this opportunity to learn. Eventually four sessions were conducted for the teens with concurrent programs for the parents. Individualizing the programs has been the "door opener" and has added to the receptiveness of the community.

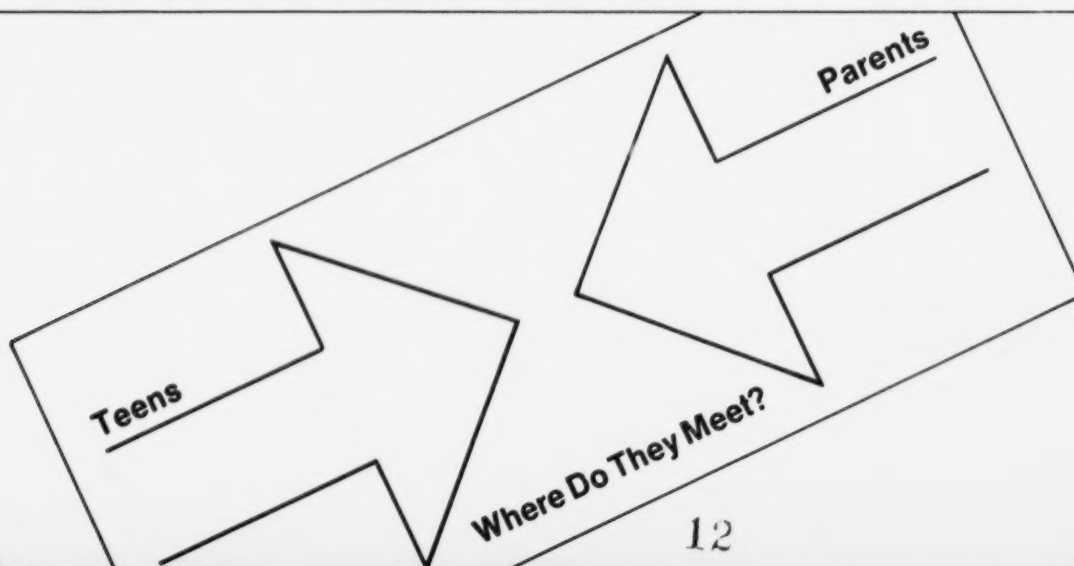
To provide outreach, the agency needed good promotional tools. A media campaign was conducted to inform the community about Project: Decision's goal of helping teens make better decisions about sexuality. The board president and a local male community leader who is also a single parent shared their insights on two 60-second spots. The teen panel members were utilized in a TV spot about a teenage athlete who is about to become a father. These spots won a local award for effective use of the media.

The benefits of Project: Decision to the department and the agency continue, from a 50% increase in the education department statistics to the growth of a new organization for which Project: Decision was a catalyst, to the teen at a drug treatment center saying, "You really gave me something to think about."

Margo Mills-Smith has been coordinator of Project: Decision for over 3 years, and will receive her M.S. in Education in the Spring of 1986. For more information, contact her at: Planned Parenthood Association of Central Indiana, Inc., 3209 N. Meridian St., Indianapolis, IN 46208.

HOW **DECISION** CAN HELP YOU

- 1. PROJECT DECISION** is designed to play a complementary role with families and various community organizations by offering:
- 2. INNOVATIVE EDUCATION PROGRAMS:** Individually tailored to meet the specific learning needs of teenagers, parent-child groups, professionals and volunteers in youth serving agencies and in health, educational and religious groups.
- 3. TOPICS** which include: "Decision Making, Communications and Self-Esteem Related to Sexuality, Saying "NO" to Sex, Becoming an Askable Parent, Becoming an Askable Adult, and Sexuality in the Media."
- 4. MALE AND FEMALE DISCUSSION LEADERS:** Professional sex educators and specially trained volunteers provide young people with positive images of adults who are responsible and concerned in their personal relationships, including sexual relationships.
- 5. PEER RESOURCES PANELS:** Young men and women, ages 16 to 21, offer audiences a chance to examine their own attitudes and values by hearing panel members' views about teenage lifestyle and costs and benefits of choices made relating to sexuality and reproduction. Panels are carefully structured to balance opinions and experiences; and are moderated by adults.



Progress for Peers

Despite opposition, this Ohio PP succeeds in implementing peer education in local schools.

by Cindy J. Biggs

Studies by a local executive task force on teenage pregnancy revealed to the Richland County, Ohio community that the teen pregnancy rate in their area was above the national average. Thus in April 1984, the Mansfield-Richland County Health Department was awarded a \$280,920 grant through the Ohio Department of Health to fund a Child and Family Health Services Project. Planned Parenthood of North Central Ohio (PPNCO) was awarded \$16,151 of that grant to train 25 peer educators in 18 months and to implement a peer education program in cooperation with youth-serving agencies, and city and county school systems.

Although PPNCO had never organized a peer education program in the past, they felt that it could serve as a pilot program to address the issue of teenage pregnancy and to better evaluate what problems the teenagers in Richland County were facing. They viewed it as a program which could combat many forms of teenage risk-taking behavior. The staff knew that other family planning agencies and drug/alcohol programs had been using peer education with some success for a number of years.

After presenting the program at a school board meeting, the Mansfield City Board of Education voted 3-2 to accept the proposal in the two city high schools. PPNCO began recruiting teens immediately after the meeting, trying to utilize the last few weeks of school to attract eager job applicants through youth-serving agencies, teachers, and guidance counselors. The peer educators would be paid for attending the initial training, for meeting twice a month, for in-service training, and for logging their contacts.

The training

PPNCO decided to train ten peer educators in the summer of 1984. A balance of gender, socio-economic levels, and peer sub-groups was desired within both schools. Applicants had to meet the following requirements: high school sophomore, junior or senior; good verbal and written skills; reliable and responsible; regular school attendance; leadership qualities; parental permission; school approval; and availability for training.

Extensive application blanks were completed and interviews were set up. By the end of July, ten peer educators had been selected and were ready for training. Meetings with their parents confirmed their permission for their son or daughter to participate in the program.

The training was held in August. The curriculum took a family life education approach and covered 30 hours of training divided into the following four phases: (1) Orientation—role of the peer educator, myths and misinformation, adolescence, and positive self-image; (2) Self-esteem—societal pressures, rights and responsibilities, assertiveness, peer pressure, decision-making, and problem-solving; (3) Health Education—reproduction, fertilization, pregnancy, prenatal care, STDs, alcohol and drug abuse, eating disorders, sexual abuse, rape and incest, and abstinence; and (4) Communication Skills—group discussion, effective communication, and listening skills.

Opposition

Before PPNCO was even told that they had received the grant monies to initiate the peer education program, a local radio program was receiving calls in opposition. This opposition developed in response to Planned Parenthood's conducting this community program, not to peer education itself. A local Right-to-Life representative had presented an alternative program at the Board of Education meeting on the same evening that PPNCO's program was presented. Planned Parenthood's program was accepted the following month.

Efforts to rescind the school board's decision were initiated and continued throughout the summer. One school board member who had opposed the program emerged as forerunner of that opposition. Taxpayers Against Planned Parenthood and the Youth Action Committee were two groups which organized against the program by circulating petitions and flyers. Letter-writing campaigns to the editor of the local paper and the other school board members were also initiated.

Both the school faculty advisor of the program and a Board of Education member were granted permission to attend the 30 hours of peer education training. During the last week of training, flyers were circulated misquoting the trainers. These flyers were distributed door-to-door and at local football games. Since the training was taped, Planned Parenthood took out a paid newspaper ad to correct the erroneous quotations attributed to the trainers.

As the school year began, opposition remained high in the schools. Many teachers would not let peer educators introduce themselves in their homerooms. The peer educators, enthused after completing their training, became frustrated in their attempts to become





Peer educators pose in one of their local schools.

known as contact people. They were seen by many of their peers as "another club."

In order to increase the program's effectiveness and to minimize controversy, the school faculty advisor officially assumed the supervision of the program within the two schools. School officials also feared that the program would have some negative impact on a then upcoming school bond issue. PPNCO's Education Director maintained minimal contact with the peer educators, except to authorize hours worked and review logs. In-service training and supervision were maintained by the school faculty advisor.

As the peer education program officially ended on the last day of school, PPNCO felt successful in making the community aware of the local teenage pregnancy problem. In mid-June the Parenting Issues Committee, formed to supervise and evaluate the program in the school, offered the following recommendations: adding a period to the high school day to allow students to sign up for more elective classes which might include sexuality education; developing a new elective high school sexuality education course; establishing student support groups at all age levels to address the needs of youngsters coping with divorce or family crisis; and requiring teachers and counselors to provide "thorough information" on all pregnancy alternatives.

Evaluation

In evaluating the effects of this program, the peer educators showed an increase in knowl-

edge after training. Self-esteem and communication skills were also improved. All the teens attended weekend training events or programs to update and add to the original 30 hours of curriculum. Their logs contained over 100 contacts each. Problem areas that were logged included: possible pregnancy, familial problems, relationship problems, birth control questions, alcoholism, drug abuse, possible VD, depression, lack of self-esteem, runaways, and Black-white relationship problems. Of all the contact areas noted, students feeling "depressed" or feeling that life was "missing something" were the most frequently noted.

During the summer of 1985 PPNCO changed the peer education format by presenting a family life education series for parents in four evenings. The programs were geared toward families with the hope of continuing to educate people about adolescent concerns, risk-taking behavior, and current issues. Like the peer educators, the attendees were seen as accurate sources of information and were encouraged to pass on their knowledge to others. They saw improved family communication in areas of family life education as a desirable outcome.

Peer education will continue among teens in Richland County whether or not it is through a formal program. PPNCO realizes that peers are the main source of information for teenagers. By training peers with accurate sources of information, risk-taking behavior can be reduced. Students will find out about agencies that can help them. And, perhaps most impor-

tantly, teens will continue to reaffirm each others' sense of worth—supporting each others' goals, needs and individual personalities—so that they will develop enough confidence to resist some of the more damaging or harmful forms of peer pressure. ■

Cindy J. Biggs is Education Director and branch program director for Planned Parenthood of North Central Ohio. While working with Planned Parenthood in many capacities for eight years, she has developed a self-esteem curriculum and has written a handbook for parents of teenagers. For more information, contact: PPNCO, 35 North Park Street, Mansfield, OH 44902.

Close-Up

DOUG KIRBY

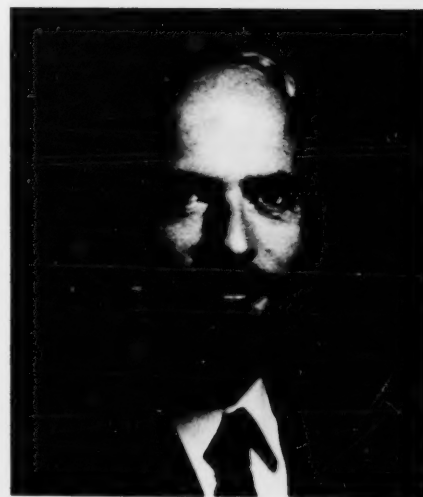
'My guess is that despite all the work that has been done in this area, it is still true that programs probably do have some impact upon some teens that is simply not measurable.'

by Michael McGee

Can we reduce the incidence of unintended pregnancy with sexuality education?

There is evidence both pro and con. On the one hand there is the Mathtech study of sexuality education that strongly indicates that exemplary programs increase knowledge, but do not have a significant impact upon sexual behavior within six months of the program. Moreover, many sexuality educators report that they still see their students getting pregnant, and of course, nationally, the increase in sexuality education has not led to any observable and major decrease in teenage pregnancies. On the other hand, a few national surveys such as that by Zelnik and Kim have found a weak negative relationship between having had sexuality education and pregnancy—students who have had such education were slightly less likely to become pregnant in later years. Moreover, during the last few years the amount of sexual activity has stopped increasing and may have begun decreasing. Similarly, pregnancy rates, I believe, may have stopped increasing. Thus, sexuality education may not have a direct, immediate, and measurable effect upon pregnancy, but it may have a less direct, a more long-term, and a more-difficult-to-measure effect. It may gradually, over time, increase young people's knowledge about sexuality, improve their communication about sexuality, and affect our culture in a positive way. In turn, these changes may help teenagers be more sexually responsible.

We should also fully realize that school-based clinics and probably other clinics which integrate sexuality education and the provision of family planning services clearly reduce unintended pregnancy. The data that have been compiled by AGI and other studies have looked at the impact of family planning, not just upon teenagers, but in general. They indicate a positive impact in the increased use of family planning. More directly related is the data from St. Paul, which measures the impact of four school-based clinics upon service utilization and teen pregnancies. A large number of teens—about 75%—use the clinic for various reasons. About 35% of the females use it for family planning. That's 35% of all females, not just the sexually active females. If you guess that half of those girls are sexually active, then more than half of the sexually active girls are using the clinic for birth control. Third, the one-year and two-year contraception continuation rates are very high. And fourth, birth rates dropped by about half



Douglas Kirby, Ph.D., is Director of Research at the Center for Population Options in Washington, D.C. He was formerly Director of the Social Science Group at Mathtech. In these positions, he has studied extensively a broad range of sexuality education programs. Reports of his findings include School-Based Health Clinics: An Emerging Approach to Improving Adolescent Health and Addressing Teenage Pregnancy and Sexuality Education: An Evaluation of Programs and Their Effects. Doug also has an article in the current issue of the Journal of School Health entitled "Sex Education—A More Realistic View of Its Effects." He shares his insights on the effectiveness of programs for teenagers with Michael McGee in this Close-up interview.

in the four schools after the clinics opened. In combination, all of this evidence makes a rather strong statement for the impact of those clinics.

What are the various studies of sexuality education measuring and why?

The basic approach that we used in the Mathtech study, and that other people have used to some extent included two basic steps. First, we identified what experts in the field believed are the most important outcomes of sexuality education programs—outcomes which in turn lead to the reduction of pregnancy. Those outcomes included knowledge, attitudes, skills, and behaviors. Second, we evaluated and measured as best we could all of those outcomes. Of course, whenever possible, researchers also measure the impact upon pregnancy and births.

If there is limited evidence that sexuality education affects behavior, why should people continue offering sexuality education?

Despite all the work that has been done in this area, I think it is probably true that programs do have some positive effects upon some teens that are simply not measurable. In each classroom, a good program may have one positive effect upon one student, a different effect upon another, etc. These separate and different effects may be important, but will not be statistically significant if someone tries to measure them.

Moreover, we should continue to offer programs because much of what is offered is important in and of itself. We think knowledge is important—information is important—even if we don't act upon it. For example, if I smoked, I would want to know that smoking is hazardous to my health, even if I continued to smoke. I think in our society we place a great emphasis upon information so that people can make more accurate decisions.

Some people in the field, and some people in other related health disciplines, have argued that the goal of sexuality education should *not* be to change behavior. Rather they believe that our goals should simply be to provide information, to teach young people how to make decisions, to make them aware of the pressures that are leading them to behave in certain ways, and then to let them decide as they like. This view is quite different from that held by some people who have entered the field because they *do* want to change behavior and do want to reduce teenage pregnancy. In my mind, both views have good arguments supporting them, but we do need to decide what our goals really are, for one type of program may increase knowledge and skills but not affect pregnancy, while other approaches may reduce pregnancy but not necessarily increase knowledge and basic skills.

How has the school clinic approach developed?

About two years ago, we only knew of 10 to 15 school-based clinics; now we know of at least 42 that are open and about 80 more which are in various states of development. I think this represents a grass roots movement around the country. Part of the reason for this growth is that funding is coming from new sources—not just those concerned with family planning, but also those concerned with many aspects of adolescent health, including undetected health problems, acute and chronic illnesses, emotional/social problems, and other risk-taking behaviors such as drug abuse. Increasingly state agencies are becoming interested and involved. They are properly recognizing that school-based clinics really do provide comprehensive care.

Years ago, when I first learned about school-based clinics, I was amazed that they could exist. But I was incorrectly focusing upon the sexuality aspects of their programs. I was aware that many communities were in turmoil over sexuality education in school and I couldn't imagine that communities would support clinics in schools that prescribed and even dispensed birth control. However, that was really the

wrong focus, for these clinics are not family planning clinics—about 85% of the visits are *not* for family planning, but for other health problems. Thus, it is more accurate to view these clinics as comprehensive clinics. This is a medical model, not a family planning model. And when clinics provide comprehensive services, more parents support them, more students use them, and more existing agencies concerned with other types of health services also support them.

What makes clinics successful?

A variety of different factors, many having to do with the fact that schools are where many young people are. The clinic is extremely accessible to students. They are likely to pass it daily, or certainly many times during the semester. They are likely to come into the clinic for other health reasons, such as for sports physicals, information, kleenex, aspirin, first aid, etc. Thus, students know where it is and what services it offers, and they become familiar and comfortable with it. Because the students are accessible to the staff, follow-up is easier. The clinic can hire staff that are trained in adolescent medicine and have special rapport with adolescents. That staff can offer educational programs in the classrooms, and thereby demonstrate that they are okay people and also help to integrate health education and practice.

Other than the school-based clinic, is there a particular educational approach or program idea that you think is more valuable than another?

After all the research that I and others have done, we ought to be able to say that a particular approach to sexuality education is much more effective than other approaches, and yet to a remarkable extent that doesn't seem to be the case—most programs increase knowledge but have little impact upon attitudes and behavior.

Having said that, which I think is the main point, there is slight evidence that particular approaches might be more useful and more promising in the future. For example, Schinke and

Gilchrist found that working with peer pressure, developing skills on how to say "No," and doing a tremendous amount of role playing did increase people's ability and probability of saying "No." Similarly, the "Say No" approach as used by Marion Howard and others in Atlanta may delay sexual activity among young teenagers.

Also, some literature in other fields indicates programs would be more effective if they meaningfully convey to adolescents the probability of their getting pregnant and the consequences of pregnancy. Educators have certainly discussed these topics, but they may not have presented them in a compelling manner. At the very least, someone should more carefully develop and evaluate this approach.

Given the particular socio-political climate of conservatism in this country, what can we do, in your opinion, to make progressive changes in teenage pregnancy?

We should fully realize that for many years there has been broad-based support for sexuality education and other programs to reduce teenage pregnancy. Most parents really want help in reducing teenage pregnancy and welcome the efforts of many groups. The opposition has typically been led by a very small, vocal minority. As was demonstrated in a Math-tech study, the greatest obstacle to programs is not the opposition, but rather fear of the opposition. We need to conquer that fear.

There are things we can do to reduce teenage pregnancy. Despite the conservatism in this country, there is great interest in and enthusiasm for school-based clinics. We can increase the number of these clinics. I think there are a lot of things that existing non-school-based clinics can do to encourage teenagers to obtain contraception earlier in their sexual career and to use it more responsibly. Clinics can set up better programs for teenagers, do more to recruit them, give them a greater amount of time, and improve follow-up. And of course, we can continue to expand and improve sexuality education. ■

The Clinic Connection

This Michigan school-based clinic leads the way with effective pregnancy prevention and health services.

by Marcia Aslakson

On the western coast of Michigan in the city of Muskegon Heights (population 14,000), school-based teen health clinics have been in operation for four years. In September 1981, a school-based health clinic opened at Muskegon Heights High School through the cooperative efforts of Muskegon Area Planned Parenthood Association (MAPPA) and the Muskegon Heights School Board. With a 95% Black population, unemployment of more than 18%, and a soaring teen pregnancy rate, the community decided to risk possible conservative scorn by taking a then radical approach to the problem. The system's superintendent and the high school principal were personally and professionally alarmed by a teen pregnancy rate higher than most other local schools.

After the high school principal visited the only school-based teen health clinic then operating, in the St. Paul/Minneapolis schools, the decision was made to present the concept to their board of directors, and it was accepted. The MAPPA executive director began making presentations about the proposed program to small parent groups, teachers and other school administrators. From these groups was formed a High School Advisory Committee which recommended that funding be sought for a pilot program with space provided by the school, and with MAPPA personnel staffing the clinic. A registered nurse and health educator/counselor were hired to provide family planning counseling and general health related services for 30 hours per week in the high school building. The student population of just over 500 pupils suddenly had a school nurse and a variety of services not ordinarily offered on the premises of a public high school.

Comprehensive care

School-based teen health clinics do cut teen pregnancy rates and provide schools with many additional health related services not ordinarily found in schools. The Muskegon Heights high school clinic has been operational since September 1981 and the middle school clinic since March 1983, offering vision screening, TB skin tests, urinalysis, job physicals, Pap smears, skin care information and treatment, family planning exams, venereal disease tests, hemoglobin analysis, problem pregnancy counseling, pregnancy tests, sex role presentations, communication skills, parenting skills, vaginal infection treatment, plus education and referral for contraceptives to the MAPPA clinic one half mile away.

Funding for the program has been difficult because the concept is new and does not easily fit into traditional funding blocks through the Departments of Public Health, Public Education or Social Services. Grants have been sought through Family Planning Grants (Title X), Maternal and Child Health Grants (Title V—National Priorities), county revenue sharing funds and City of Muskegon Heights block grant development funds. In 1986 funding will finally stabilize, thanks to the two state legislators from Muskegon County, through the Michigan Department of Public Health. Ideally, \$80,000 start-up costs for renovation, equipment and staff salaries were needed. This clinic never had full start-up funds, so that most equipment was donated. Necessary materials are added each year as budgets permit.

Clinic Utilization by Service and Year

Services	# Visits 1981-82	# Visits 1982-83	# Visits 1983-84
Family Planning Exams			
Initial	34	28	27
Annual	1	15	32
Total	35	43	59
Medical Problems			
Non-Family Planning	943	1428	1024
Family Planning	16	7	92
Pregnancy tests	19	21	44
Other Laboratory Work	57	66	85
Birth Control Supply Visit			
Prescription, Female	22	53	112
Non-Prescription, Male	31	105	83
Non-Prescription, Female	4	18	37
Referrals	267	510	634
Walk-ins	289	396	714

Following the recommendation of the Advisory Committee from the high school, a second clinic was started in March of 1983 in Muskegon Heights Middle School (student population 450). Data collection during the 1983 calendar year calculates to a 0.6% pregnancy rate (one abortion and no births) for the middle school population. This figure compared to the 14 live births in the 1979-80 school year, shows the effectiveness of sexuality education and referral for family planning to the MAPPA offices as having an impact on teen pregnancy. Middle school students share counseling sessions on puberty in classroom presentations to help them understand what is happening to their bodies.

In conclusion, what is needed for the successful implementation of a school-based teen health clinic is the desire to have an impact on teen pregnancy, a cooperative effort by the

school board, administration, teachers and parents, and a Planned Parenthood affiliate concerned enough to search for a funding base to start. The rewards can be fantastic—a lower teen pregnancy rate, a school nurse in the building, and educational presentations both in clinic and in classrooms ranging from specific family planning programs to alcohol/drug abuse and mental health presentations. Muskegon Area Planned Parenthood Association has a packet of materials available for \$10.00 which gives more details and information on how to start a school-based clinic in your community. ■

Marcia Aslakson is Community Relations Director of Muskegon Area Planned Parenthood Association. For more information contact MAPPA at 1642 Peck Street, Muskegon, MI 49442.



A typical clinic visit at the middle school.

Accent on . . .

ELECTRONIC SEXUALITY

"Electronic Sexuality"—a forum with a catchy title but a serious purpose was held in Milwaukee in April 1984 under the joint sponsorship of Planned Parenthood of Wisconsin-Greater Milwaukee Chapter and WTMJ Radio. First introduced to Milwaukee in September 1983 and organized by Planned Parenthood-Milwaukee's community educator, it focused on the Black community. The success of this forum and the interest it generated in the topic provided the impetus for the 1984 forum. Over 300 youth and adults attended the two-hour program in which a panel of disc jockeys, community leaders, clergy, parents and teens discussed the influences of popular music on teen behavior.

The positive responses to the forum reflected a growing concern on the part of many parents and other adults about the effect of sexually explicit, often violent messages given to young people through popular music. During adolescence young people typically listen to more music than at any other period of their lives. It is a time when they are separating from their parents and achieving individuality.

The question of whether teen sexual attitudes and behavior are influenced by music was addressed by the panelists. Although no consensus was reached, the purpose of "Electronic Sexuality" was achieved: to create awareness of the lyrics of popular music aimed at teens, to discuss the possible effects, and to open discussion among parents, teens and others. In addition, "Electronic Sexuality" brought together twenty-one youth-serving organizations as co-sponsors. Their cooperative efforts ensured the success of the event. For more information contact Diana Magness at Planned Parenthood of Wisconsin, Inc., 744 N. Fourth Street, Milwaukee, WI 53203. ■

Humboldt Heralds FLE

In rural California, parental support helped forge the development of this FLE program.

by Randy Crutcher

According to recent polls, parents around the country are saying that they want help in giving accurate information and skills to their children at an early age to prevent the often tragic circumstances of unplanned and unwanted teenage pregnancies. Only one out of ten children in the nation actually receives a comprehensive sexuality education program or course in school, underscoring a shocking disparity between the need for school programs and the lack of success at delivering them.

In California's rural Humboldt County, the teenage birth rate is half that of neighboring counties with similar demographics and economies. Health educators at Six Rivers Planned Parenthood (SRPP), based in Eureka, California, proclaim a high correlation between the downward trend in teen births or sexually transmitted diseases and the ongoing efforts in the 13 schools where they teach family life education. A ten-day program is presented in a state required class for high school sophomores in four out of six high schools and two out of three alternative high schools. A five-to-ten-day program is presented in seven elementary schools at the sixth, seventh and eighth grade levels. These school programs alone reach nearly 2% of the entire county's population. In one of the high schools and in several elementary schools that the health educators do not actually visit, model training programs have been provided in an effort to help schools assume primary responsibility utilizing their own staff. Because of shifting staffing patterns, the trainings need to be frequently available in order to maintain quality and competence in instruction.

Curriculum acceptance

In 1977, SRPP, in conjunction with the Humboldt County Health Department, formulated school curricula and training programs for family life educators which were appropriate to the region. A careful step-by-step process was employed, beginning with contacting local schools to survey existing programs and resources. Interested principals were supplied with curricula materials and could request extra copies of the curriculum for school board members to review. The principals presented the curriculum and program for approval at a school board meeting during which health educators furnished teaching materials and audiovisuals. At that time educators also answered questions the board had about curriculum content or teaching techniques. After school board

approval, health educators met with the principals to arrange times and dates for the family life education program and the parent review evening.

Parents were notified in writing at least two weeks in advance of the upcoming program, including being sent permission slips which showed the time and date health educators were available to discuss teaching methods and materials. The principals, the classroom teachers in whose classes the program was to be taught, and the health educators all attended the parent review evening. At that time, parents decided whether to permit their children to attend, and 96-98% of the parents decided in favor. The five or ten-day program was presented to those students with positive permission slips. Other students had an alternative assignment in the library during that classroom time.

Since studies indicate that the single greatest barrier to implementing school programs is the school administrator's fear of opposition, whether it actually exists or not, the presence of an advisory group is a key factor to success. School boards and administrators must sense or experience a healthy and positive support for family life education before they will commit to decisive action.

Alleviating controversy

In keeping with the fact that parents are the primary sexuality educators of their children, the advisory group has helped initiate parent-child communication workshops, ongoing support groups for parents of teens and public awareness campaigns regarding family communication about sexuality. This has helped to alleviate fears in the community that the school system is taking over rather than supporting the parents' role in family life education. The advisory group has networked an increasing number of interested parents, thereby demonstrating broad-based support for school programs when adoption of curricula and programs has been placed on the school board meeting agenda. The advisory group has been well informed as to the content and teaching techniques in the proposed program and has been able to relay this information to all who are interested. After school board approval, the same steps listed earlier have been taken to bring the program to the students. Through this community coalition effort, administrative, school board or parent resistance has been dealt with in an informative and supportive manner, thereby ensuring the continuity of a school family life education



Teachers captivate students in this FLE class.

program.

Another important criterion for success has been in the area of curriculum development. Curricula must be responsive and respectful of individual communities and a broad spectrum of family and religious values if they are to be accepted. They must also contain the facts and skill-building lessons that maintain the objectives of reducing unintended pregnancy, sexually transmitted diseases and the physical and emotional damage of unhealthy relationships.

Six Rivers Planned Parenthood has provided individual school districts with different course outline options to choose from and has relied on an annual ad-hoc community advisory group composed of parents, teachers and clergy to review updated and revised curricula. Within the last two years, both the 6th, 7th and 8th grade and senior high school level curricula have been expanded to include world population concerns and prevention of family or dating violence. One elementary school that recently adopted a program did so because personal violence prevention was being included in the curriculum.

Other areas which have been addressed in a comprehensive program include: reproductive anatomy/physiology; intrauterine development; birth; sexually transmitted diseases; peer pres-

sure; sexual activity; assertiveness training; birth control; the benefits of abstinence; teen pregnancy; teen parenthood; sexual decision-making; marriage; and family types. In addition, the sixth, seventh and eighth grade programs have included male and female hygiene and special sections on body image, identity, self-esteem and peer pressure.

SRPP does not pretend to have all the answers when it comes to getting family life education into the schools, but they certainly have made more than an impressive start. ■

Randy Crutcher, M.A., Director of Education, has worked in family planning and education since 1978. As a project director for a state funded male involvement pilot project "Everyman's Center" he wrote "The Emerging Male," a man's handbook. For more information, contact: SRPP, 2316 Harrison Avenue, Eureka, CA 95501.

How to Say No

Building sensitive communication skills is the goal of this PSI program for central Pennsylvania youth.



by Patricia Brogan and Patti O. Britton
Planned Parenthood of Lancaster County (PPLC) began offering the Postponing Sexual Involvement (PSI) program in July 1984. Based upon the series originally developed by Dr. Marion Howard of Emory University in Atlanta, the nationally available program provides teens with the communication skills to say "No" to sexual intercourse. Through funding provided by the Family Planning Council of Central Pennsylvania, Marion Howard trained staff in all of the council's delegate agencies to provide the PSI series throughout central Pennsylvania. These agencies consist of Planned Parenthoods and other family planning providers or clinics with education staff who might deliver the PSI program. As a Planned Parenthood affiliate, it was easy for PPLC to decide to conduct this type of program, for they had already been educating teens and others about how to say no to undesired sexual intercourse.

While many sexuality educators may assume that the primary question for teens is whether or not to engage in sexual intercourse, for many teens the issue is rather one of how to say no to sexual intercourse, and how to communicate this choice without hurting someone else's feelings. The PSI program series addresses this issue and offers teens the tools to do just that. This program is designed specifically for early and pre-teens; there is also a component of the PSI program for parents. The content of the two differs slightly and overlaps. The PSI series for parents is a two-session presentation, and the series for teens, created for use with teens between the ages of 12 and 15, is a four-session series. Ideally they can be used together with parent and teen groups, independently or concurrently.

Parents' process

During the parents' training, the first two-hour session presents information and exercises related to social and peer pressure. Topics encompass the general nature of relationships, sources of societal pressure influencing sexual behavior, and assertive responses which teens can use in peer pressure situations. The goals of the parent series are: (1) to help parents understand the pressures in our society which influence young people's sexual attitudes and behaviors; (2) to give parents tools to share with their children that will assist them in postponing sexual involvement; and (3) to encourage teens to postpone sexual involvement and therefore prevent unwanted pregnancies.

Postponing Sexual Involvement

"HOW TO SAY NO"



An Educational Series
For Parents of
Young Teens



This is accomplished in several ways: by examining values and attitudes including the social pressures on teens to become sexually active; by acknowledging the feelings young teens have about their developing sexuality; by learning and practicing some assertive techniques that can be shared with teens; and by discovering ways to share this information. The parents' component was created to enable parents to provide reinforcement for their children.

The series component for young teens provides the participants with tools to aid them in bridging the gap between their physical development and their cognitive ability to handle the implications of such development. The intent is similar to that of the parents' component. The desired outcome is sharing knowledge and offering skills to young people that are expected to help them deal with problem situations, such as postponing sexual involvement until a time when they are better able to make decisions around issues which have a long-range impact on their lives.

The goals of the teens' series are: (1) to help young people understand the pressures in our society which influence young people's sexual behavior; (2) to help young teens deal with pressure situations through the use of assertive responses; (3) to help young teens understand their rights in social relationships; and (4) to help young teens postpone sexual involvement.

The full program for youth follows a specific process. Session One: Social Pressure—presents information and exercises using: small group activity, testimonials, case study, slide presentation, learning responses, and covers why teens become sexually involved as a way of meeting various needs as well as alternatives for meeting some of them. Session Two: Peer Pressure—presents more information and exercises related to the topic using: understanding the right to say no, learning responses, more group work to enable the young people to understand peer pressure in group and individual situations. Session Three: Problem Solving—also presents relevant information and exercises using: handling difficult situations, showing feelings in physical ways, stating feelings and using assertive techniques, pressure "lines" and assertive responses to promote understanding of ways to look at limiting expressions of physical affection with guidance in how to handle difficult social situations. Session Four: Using New Skills—reinforces the prior three sessions through: new skills discussion, game show and mini-skits presentations to review skills already demonstrated and offer an opportunity to practice additional skills. This final session is held several months after the others. Many of the teens' skills are developed through role-playing. In the central Pennsylvania programs, many of the teens have expressed that they particularly enjoyed this aspect of the program.

Many sexuality educators nationwide have questioned the degree to which birth control information should be presented as part of the PSI series. The series is designed for those young teens who have decided to postpone sexual involvement, thus precluding an immediate need

for specific birth control information. However, central Pennsylvania providers are aware of the needs of a significant number of teens who have not postponed sexual involvement, and they have made birth control discussion available upon completion of the four-session series. These providers regard the PSI series as a supplemental program and they conclude that learning how to communicate decisions about sexual activity is a valuable component of comprehensive sexuality education.

The PSI series includes an audiovisual component in the form of a slide presentation, and many of the local young persons who participated in the series commented negatively about its value to the overall effectiveness of the program. PPLC staff find that the slides are not crucial for delivering the PSI message or teaching the appropriate skills, and so they use other materials such as trigger films. PPLC staff stress that there are many ways to talk about social and peer pressure and that all professionals should be able to adapt the PSI program for their own use.

The negative aspects of the program are few. It cannot be viewed as a panacea for the problem of unintended teen pregnancies—as yet there is no such ultimate program. The program

is laudable in that it can be adapted for what is best for each community. Regardless of whether the PSI participants are struggling with the decision of whether to engage in sexual intercourse, each one can derive something valuable from learning to say no without hurting other people's feelings. The young persons in the PSI series are building some important skills and values—self-esteem, assertiveness training, and communication techniques. These are skills that can later be used in other areas, that will enhance their lives in the future.

There are several positive aspects to the PSI program. It allows the agency to reach a different population from their usual target groups. The series for parents enhances family planning providers' commitment to parent education, optimizing an opportunity to offer peer education without the usual isolation from family involvement. Finally, it has superb credentials, is highly marketable, and meets a crucial need expressed by young teens. ■

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A Cornucopia of Care

Helping teen parents and their families with practical support is the goal of these model programs.

by Cathy Ahart

In 1983 Planned Parenthood of Mid Central Illinois (PPMCI) designed a four-part program to serve pregnant, parenting and at-risk adolescents in McLean County. The Adolescent Parent Program for Learning Essential Skills (APPLES) began as an Ounce of Prevention Fund program through the State of Illinois' Parents Too Soon initiative (PTS).

One of two programs funded in a sixteen-county region, APPLES is considered a model program because of the comprehensive manner in which it addresses the issue of adolescent pregnancy. Designed by PPMCI administrative and educational staff, APPLES develops and coordinates services to adolescent parents and provides expertise and strategies for educating at-risk adolescents. APPLES currently has the support and cooperation of sixteen youth-serving agencies.

Program components

One essential element of the APPLES program is the Home Visitor Program. Under a subcontract with the McLean County Health Department, each APPLES Home Visitors team is made up of one registered nurse and one social worker. The Home Visitors provide aggressive advocacy tailored to the young family's special needs, such as securing adequate housing, transportation, child care, or financial assistance.

In addition to assisting young parents to obtain services from other agencies, APPLES Home Visitors provide in-home, one-on-one education. Home Visitors assess the child's developmental progress and teach the parents what developmental skills to watch for. A home visit may include bringing baby scales and tape measures to help parents chart infant growth, or bringing a bag of sample birth control methods to discuss family planning, or even bringing bus schedules and tokens and actually riding with a parent to show her how to transfer.

Local senior citizen volunteers donate handmade baby items, and agencies and individuals donate infant clothes and baby furniture to be distributed by the Home Visitors. Because of the concern and generosity of the community and the creative encouragement of the Home Visitors, the young parents can progress from their initial feelings of isolation and alienation to a feeling of being part of the community.

Through the cooperation of neighborhood churches and community centers, APPLES offers "Time Out," a weekly peer support group

that provides an opportunity for adolescent mothers to share the frustrations and triumphs of parenting. The groups are facilitated by trained volunteers, some of whom were teen mothers. Time Out is a short-term (3 to 4 month) empowerment/affirmation model that integrates information sharing, consciousness raising, education, and skills development. The empowerment content varies from group to group depending on the special needs of the participants but always includes enhancing self-esteem and developing life skills, from assertiveness to budgeting. As the groups develop, they are encouraged to identify and establish special needs co-ops that will meet their needs, such as transportation and childcare.

While mothers are taking Time Out for themselves, their children are cared for by trained child development volunteers. They use creative play and individual assessment to develop a new activity each week for the mother and child to do at home. These activities are designed to promote mother/child interaction and to motivate the mothers to take an active interest in their child's development. Volunteers provide transportation and nutritious snacks on meeting nights so that mothers can get to Time Out.

The Developmental Day Care component provides adolescent parents with alternatives and partial financing for child care to allow them to continue their education or job training. APPLES staff work with both care providers and young parents to locate day care facilities. The PPMCI education staff offer in-service training to the providers and to educate them about working with adolescents to achieve developmental goals in the children.

APPLES also encourages the adolescent parents to initiate child care co-ops so that parents can attend GED classes or work. Educational toys, help with coordination, and a small financial incentive are offered as motivation for the development of the co-ops.

**Grandparents
Too
Soon**



*...if you
feel like it,
you are.*

You're a Teen

You're a Parent

You have Rights



**Parents
Too
Soon**

Male program

ADAM is the support component for adolescent fathers. It works through the PPMCI education staff, to promote awareness, education and prevention for the at-risk adolescent population.

ADAM encourages adolescent fathers to be informed of their rights as well as their responsibilities, and provides counseling and support for these young men. Originally, ADAM offered group support meetings for the fathers, but adolescent fathers were uncomfortable and reluctant to take advantage of this service. Therefore, ADAM launched an outreach campaign to provide information and access to the resources available. Trained outreach volunteers hiked, biked and rollerskated to street corners, community centers, housing projects and wherever young men were congregating to be visible ambassadors to the young men on their own turf. One of the most effective discussion-starting tools is the "six-pack," an introductory kit of condoms. ADAM has sponsored successful community events such as weekly gym nights, a boxing clinic, breakdancing contests, and holiday parties. All of the activities included film presentations of "Teenage Father," or "If You Want to Dance . . ." or "What Can a Guy Do?" or trigger films to stimulate discussions focusing on men's roles in family planning and parenting.

With PPMCI's education staff, ADAM offers a speakers' bureau and audio-visual materials that are used in churches, schools, and at community workshops to assure that accurate information is available so that at-risk adolescents can make informed decisions regarding their sexual activity, family planning and parenting. ADAM has also sponsored a Father's Day Essay Contest, father/son workshops dealing with sexuality, a training seminar for professionals on counseling young men and boys, and many displays and community presentations. ADAM staff wrote and published an informational booklet, "You're a Teen, You're a Parent, You Have Rights," to answer adolescents' legal questions about their children.

Guidance for grandparents

In early 1985, APPLES developed and published a pamphlet with questions and answers for the parents of adolescent parents. The overwhelming response led to the development of the Grandparents Too Soon (GTS) service addition to APPLES. Networking links trained GTS participants with new or very stressed grandparents. Brief educational/support group sessions for GTS were initiated to center on peer help in dealing with their feelings, fears and frustrations. APPLES also sponsored a training conference for professionals focusing on the unique aspects of this family crisis and including strategies for meeting their needs.

The staff has seen concrete results of APPLES effectiveness through increases in teen parents' completing GED requirements, returning to high school, pursuing higher education, securing and keeping jobs, and avoiding unwanted second pregnancies. But it is the individual responses that reinforce and energize both staff



Children and care-giver in the Time Out program.

and volunteers. Some comments include: "I felt all alone before you started visiting me." "I know now that there's a lot of guys that feel the same way I do about being a father." "One of the mothers from my group kept my son while I was in the hospital, and another stayed with me while I was in labor." "[My Home Visitor] thought something was wrong with the way [my three-year-old] talked. So she helped me have him tested, and she was right! We got him into a special class at [the university] for kids with hearing problems." "If it hadn't been for my baby-sitting co-op, I'd never have been able to even think of junior college."

But not all of the success stories belong to APPLES participants. Community involvement

with and support of APPLES has been an effective door-opener with people not historically linked with Planned Parenthood. By encouraging community cooperation through APPLES, PPMCI not only demonstrates Planned Parenthood's commitment to pregnant, parenting and at-risk adolescents, but also increases the community's awareness of the Planned Parenthood mission of promoting strong and healthy families. ■

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MY MOM NEEDS



Dallas Drama in Demand

Contagious enthusiasm brings family life education to a broad audience through the Dallas PP teen theatre.

by Elena Love

In the brief three-year period Planned Parenthood of Greater Dallas (PPGD) has been serving the Dallas community, the agency has established itself as a respected resource for reproductive health care education. This accomplishment has led to many invitations for PPGD staff to participate with other community organizations and ad hoc committees to review and evaluate local sexuality education programming.

Early in 1984, the PPGD executive director, Jim Roderick, and the agency's education director, Elena Love, were asked to participate on the Mayor's Task Force on Adolescent Pregnancy in Dallas County. In the course of the committee's investigation, a group of teenagers who were also members of the task force made several recommendations for improvements in local health education programming.

The teens envisioned an "upbeat" educational vehicle which would employ local adolescents trained as peer health educators. They described a project which would caution, but not lecture, them about the obstacles they might encounter in adolescence. These recommendations echoed plans for program development already being considered within the PPGD education department.

Several months before the task force's formation, Jim Roderick had seen a performance of an improvisational teen theatre troupe sponsored by a Planned Parenthood affiliate in California. He had been impressed by the program both because of its educational content and its polish as a dramatic production. Jim returned to Dallas with a contagious enthusiasm for the teen theatre concept.

Board approval

Before long, the PPGD education department was ready to commit to the development of a teen theatre troupe for Dallas. Encouraged by the Mayor's convening of the adolescent pregnancy task force and reinforced by the teenagers' recommendations, the PPGD staff brought the teen theatre project proposal to its board for approval. Board approval was reached with enthusiasm, as the board members shared the staff's confidence that the right time had come to carefully select a group of adolescents, and with a solid training program, to develop them into skillful teen peer educators.

Since funds were not immediately available to develop the project, the decision was made to finance the theatre troupe during the first year with income from patient fees, and to seek com-

munity and corporate support as soon as the project established a successful track record. The initial expense would be viewed as an investment in educational program development for the community.

The PPGD teen theatre troupe, named Teen-Age Communication Theatre (TACT) by the 1984 cast members, is based on the model for educational teen theatre which originated in New York in 1973 at the Family Life Division of New York Medical College.

It was determined that \$100 would be a reasonable fee for organizations seeking a TACT performance. However, six weeks into the 1984 season it became apparent that some local youth serving organizations were unable to pay this amount. With this new information, the TACT Coordinator wrote a grant proposal for funding to underwrite performances for organizations which could verify their inability to pay the performance fee. The grant request was for \$1,000 to support ten performances. The grant was distributed to five potential funding resources, and support was received from three. With \$3,000 in reserve, PPGD was able to ensure that all organizations seeking a TACT performance could be accommodated, regardless of their ability to pay.

The TACT production

TACT is a three-part production which lasts approximately one and a quarter hours. Part One consists of a series of short, improvised skits which the cast members have created from issues of concern for themselves and their peers.

Topics during the 1984 season ranged from peer pressure and teenage pregnancy, to adolescent depression and post-divorce adjustment. Many, but by no means all, of the skits focus on sexuality issues. This decision, to broaden rather than restrict the production's subject area, underscores TACT's awareness of the interrelatedness between adolescent sexual activity and other behaviors such as substance abuse and suicide. Some of the skits are humorous, some heartrending—all are authentic.

In Part Two, the actors return to the stage remaining in character, and invite questions and comments from the audience. Since the skits have been left unresolved, audience members now have a chance to question the characters about their motivations and behaviors. This part of the TACT production is powerful because the audience has an opportunity for immediate involvement with the cast and subject matter,



The TACT troupe.

unlike traditional dramatic productions.

Part Three is structured to allow the actors to introduce themselves and to field questions about their participation in the TACT project.

Staffing and casting

PPGD's education director was chosen to develop the teen project and serve as its coordinator. Since she was an established member of the local health care community, she was immediately welcome in classrooms, religious youth group meetings and recreational facilities. Having easy access to already convened groups of adolescents made recruiting for auditions a manageable task.

The first cast consisted of eleven teens who ranged in age from 14 to 18 and who represented seven area schools. Five of the 1984 TACT members had some previous acting experience, and six had none, but were attracted to the project because of its potential as an educational resource and an emotional support for themselves and their peers.

Community response

TACT premiered in October, 1984 at the PPGD conference at Southern Methodist University in honor of National Family Sexuality Education Month. Audience response to the first performance was flattering. In fact, public

response to TACT's entire premiere year was unanimously favorable.

Throughout the 1984-85 season, TACT was continuously in demand. This is remarkable in that little effort was made to "market" the production. The solid reputation established by the PPGD education department was apparently sufficient to attract people to, and to talk about, the agency's new community education offering. In nine months TACT performed before more than 5,000 people in a wide variety of settings and for audiences which represent a broad range of social, racial and economic backgrounds.

Undoubtedly, community response to the first season of TeenAge Communication Theatre can be attributed to the care and thoroughness with which the production was developed. TACT members spent over forty hours in educational classes during the summer of 1984 learning about the subject areas from which they eventually formed their skits. During the 1984 season TACT members rehearsed several hours each week to refine their performances and to develop new material in response to audience recommendations.

Throughout the year the TACT members studied, rehearsed and performed with an energy and intensity that is the signature of the most attractive aspect of adolescence, and their prep-

aration was rewarded with considerable community support.

There is every reason to believe that last year's success was not a fluke. By the first of September 1985, TACT had already been contracted for performances at adolescent issues, regional and national family planning conferences, and in other settings. This year's production will reach more than twice the number of people as the 1984 season.

The TACT experience has left no doubt in the minds of its founders that Dallas was ready and eager for this teen peer educational vehicle that vividly conveys the connection between behavior and consequences and that inspires people to communicate candidly about sensitive issues. ■

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Courting Challenge

*In tandem with
Juvenile Services,
this PP program
touches teen lives in
constructive ways.*

by Jaxie Farrell

"Why does it feel good when I'm doing it but the next day I feel bad? . . . Why do men use women? . . . Is it really stupid to get pregnant when you're a teenager? . . ." These are some comments and questions from teenagers in an alternative learning program during a series of classes on human sexuality. Some of these questions may not appear to be different from those asked in a regular high school classroom, but the discussion following them is very different, and in many ways the educator is constantly challenged by these students.

In 1981, Planned Parenthood of Walla Walla (PPWW) accepted an invitation from the office of Juvenile Court Services to teach classes to teenagers on probation or parole who were attending an alternative learning school. To meet this challenge and to provide realistic sexuality education for this special group required planning, experimentation and hard work. The Juvenile Services staff were keenly aware of a need when faced with a high rate of teen pregnancy, sexually transmitted diseases, frequent drug abuse and consequent sexual exploitation and irresponsibility. At that time all the students were juvenile offenders; now there are also students who have been unable to progress in the public system for a variety of reasons, including pregnancy and drug abuse. The sexuality education classes, then optional for students, were held after school and concentrated on contraception and pregnancy. Most often only a few, if any, students attended. The classes then were obviously not meeting the needs or interests of the students.

The public school curriculum also seemed inadequate even after instituting a human growth and development class for sixth graders in the Walla Walla School District in 1977. With its focus on reproduction and family relationships there was little or no follow-up or required sexuality education in later grades. Although most students in the alternative school are 14 and older, and have been through the human growth class, they have very few concrete facts and limited decision-making skills in the area of sexuality. Unfortunately, the majority of students are sexually experienced but *not* sexually knowledgeable.

It was relatively simple for PPWW to adapt programs for marriage/family life and psychology classes presented in the public schools for longer class periods and broader discussion. Staff presented outlines of the class sessions to the alternative school and Juvenile Services

staff which were readily accepted, and classes were started in 1982. An annual fee is charged to Juvenile Court Services for education services. Students are required to attend classes during regular school hours unless a parent fails to give consent for them to participate in the human sexuality course. Thus far, no parent has refused consent.

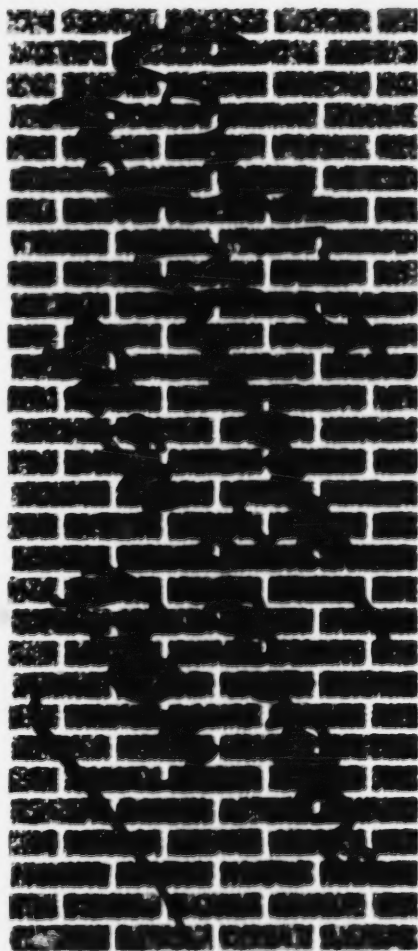
Class content and structure

The new curriculum was developed by expanding materials already used in the high schools by the PPWW health educator. These materials, for the most part, are based on formats, exercises and information used throughout Planned Parenthood affiliates. The focus has been shifted to decision-making; however, contraception, anatomy/physiology and sexually transmitted diseases remain in the curriculum. These subjects are presented in four or five sessions and do not always follow the same sequence.

The classes are usually coed but for some groups it has worked better to divide them. Often, the girls are more willing to self-disclose when the boys aren't there. The boys do not seem as intent to appear macho and "know-it-all" when the girls aren't in the classroom. But the coed classes are also successful because the interaction points out sex roles, conditioning and myths that can be explored from both male and female perspectives. Discussion on contraception is usually heated when the issue of shared responsibility is presented, especially regarding casual sex.

Very often the classroom teachers do not stay in the room. This encourages students to be more open and expressive. The PPWW educator may become more vulnerable to direct challenge but this has not proven to be a problem. In general, students respect her as a visitor and are so interested in the topic they are not disruptive. This is especially true if she has gained rapport with them by accepting every question and challenge.

The programs used for these students are the same as those presented to teenagers by PPWW in public high schools, rap groups, and church groups—even a fundamentalist school. The need for basic information is exactly the same. However, when presenting information to juvenile offenders, high school dropouts and teen moms—which is the population of the alternative school—there is no guarantee that any format can be followed step-by-step. For instance, these classes have been presented to a group of



male juvenile sex offenders, aged 12 to 16. With this group the emphasis was on personal rights, communication, and consent issues. For them, these particular issues had special impact, but the practical information regarding birth control, sexually transmitted diseases and teen pregnancy was also important. Information about growth and development was an important issue because some of these offenders had molested and raped children without any concept of anatomy or concern for consequences.

The following components of the series are adaptable and change according to the needs and direction of the students:

►The first class is usually anatomy and physiology. In an opening exercise students in dyads draw and label male and female reproductive anatomy from terms listed on the board. This allows time to laugh, be nervous, use slang, and reduce tension. A lecture on anatomy and physiology with illustrations follows, and always includes questions on sexual behavior, sexual response and life-styles.

►The second class can be a fertility awareness session, particularly if it is just girls, or it may be a discussion on teen pregnancy and parenting. This can include the film *Teenage Father* as a tool to include male involvement issues in the discussion.

►Contraception is the subject of the third session. It includes passing each method around for touching, smelling and, in some cases, tasting. Discussion on responsibility for birth control is sparked by use of the decision-making tree. Abstinence and options to sexual intercourse are discussed at this time also.

►Sexually transmitted diseases is the topic for the fourth session. An anonymous survey of attitudes regarding STDs opens the way for

information about reporting symptoms, treatment access and communication on disease.

►Decision-making about sexuality incorporates all the information from previous classes. Students are presented with a decision-making model and are asked to list positive and negative consequences of choosing to have sexual intercourse. The educator explains how needs for intimacy, caring and love get confused with sexual needs. Sexuality is defined, and students learn the importance of understanding themselves and working toward a positive approach to expressing their sexuality. Because most of these students are already sexually active, the emphasis is on sexual decision-making continuing throughout our lives. Factors included are communication, self-esteem, assertiveness and values.

Contrasts

In thinking about what makes the program special, it differs from the traditional in unique ways. In contrast to the public school classroom where students represent varying value systems, opinions and experiences, these students are a more homogeneous group. Although the type of experience may differ, their struggles and responses are similar, and attitudes are more closely akin to each other. Thus, unlike other groups, it is difficult to point out ranges of opinions and ideas to illustrate cultural myths and help overcome stereotypes. There may also be very strong sex role stereotypes in this group. Many of these students lack positive role models and the educator may have to present that positive modelling. Another difference is the age range of 14 to 19 with varying levels of learning and skills. Finally, when working with this vital group, there is a sense of urgency, a need

to get everything possible across to them in a very short period of time.

The key components required of the educator in this decision-making series are flexibility, honesty and an unfailing sense of humor. In addition she/he must be well grounded in knowledge of human sexuality, a knowledge that is constantly tested in these classes by every kind of hearsay, myth, and media hype. The exciting part of teaching this series is the intense involvement with students that occurs in a very short period of time.

The alternative school setting lends itself to greater self-exploration and the students feel free to ask straightforward questions and make strong statements. Questions at first are usually posed for shock value and the terms are nearly always street language. But after having every question answered honestly, they become more serious and the language less colorful. These students force the educator to take risks and to confront issues head-on. A special bond develops between educator and students as a result of this non-judgmental approach. Students often privately ask poignant questions of the educator after each presentation. For the educator this is an exhilarating teaching experience.

It is hoped that through PPWW's special program these teenagers will find more positive definitions, answers and tools to make responsible sexual decisions for themselves. ■

Jaxie Farrell has been the Education Director/Health Educator for PPWW for the past 3 years and is in private practice as a sexuality counselor in Walla Walla. For more information contact her at PPWW, 136 E. Birch Street, Walla Walla, WA 99362.

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This selected bibliography of recent books and journal articles relating to teen sexuality and reproductive health was developed as a supplement to the Winter 1985-86 issue of Emphasis -- "Conflict and Challenge: Teen Programs Today." This compilation of annotated references is divided into sections focusing on issues which confront not only teenagers themselves but also those who are concerned with their development and education. The topics of focus are: Sexuality Education, Contraception, Parenthood, Communication with Parents, Reproductive Health, Sexual Behavior, School-Based Programs, Teenage Life in General, and Male Involvement.

SEXUALITY EDUCATION

Books

A BASIC LIST OF SEX EDUCATION RESOURCES, Ed-U Press, comp. Fayetteville, NY: Ed-U Press, 1984. unp. \$5.00.

Updated annually, this list includes national organizations, government agencies, religious organizations, journals and newsletters, toll-free hotlines, books for all family members, references for school and community service personnel, references for religious leaders, references for the disabled, general reference works, and a list of publishers.

FIRST LOVE: A YOUNG PEOPLE'S GUIDE TO SEXUAL INFORMATION, Ruth Westheimer and Nathan Kravetz. New York: Warner Books, 1985. 212 p. \$3.50. ISBN 0-446-34092-8.

Written for both parents and teenagers, this easy-to-read guide presents information on a variety of sexual matters. Topics include: differentiating sex and love; reproductive physiology; virginity; contraception; masturbation; homosexuality; being accepted by peers; rape and abuse; venereal disease; feelings; whom to turn to for counseling and help. WARNING: A typo on p. 195 makes an incorrect statement about the "safest" time of the month to have intercourse. The correct word on line 6 is "unsafe" not "safe." The publisher is recalling copies of the book and correcting the error.

"WE'RE NOT JUST TALKING SEX . . ." A LEADER'S GUIDE FOR TEEN SEX EDUCATION, Katherine Whitlock et al. Philadelphia: Planned Parenthood Southeastern Pennsylvania, 1983. 130 p. \$12.95.

Written for adults (not necessarily health care professionals) who wish to introduce teenagers to sexuality education programs, this guide describes general principles of effective programming as well as reproductive physiology and contraception. Outlines for programs on health care, values and decision-making, and sexuality and relationships, as well as instructions for program evaluation, are provided. Print and AV resources for teens, parents and professionals are listed; appendices detailing anatomy, STDs, health care, contraception and rape are included.

Articles

ALEXANDER, SHARON J.

Improving sex education programs for young adolescents: parents' views
Family Relations, April 1984, 33(2), 251-257

Parents of young adolescents from two communities were surveyed regarding their attitudes toward sex education. The major findings were that parents wanted to be the primary sex educators of their children and that they wanted schools to supplement their efforts. These parents wanted diverse topics covered by schools and wanted them introduced no later than ninth grade. Implications for researchers and educators are presented.

BLAIN, GERALD H. and BRUSKO, MARLENE

Starting a peer counseling program in the high school
Journal of School Health, March 1985, 55(3), 116-118

Peer counseling has become more prevalent in high schools nationwide. Programs fall into two general categories based on their purpose and group composition; open models, where students are trained to help other troubled students in their schools, and closed models, in which students are trained to help themselves. This study provides a practical, working description of the open model as implemented in a large, suburban high school.

BRICK, PEGGY

Adolescence in perspective: a lifespan approach to sexuality education
Seminars in Adolescent Medicine, June 1985, 1(2), 139-144

Sexuality education during adolescence is part of a process begun in childhood and continued throughout life. A lifespan approach to sex education respects the full personhood of adolescents and allows them to gain essential insights about their place in the continuum of life. Suggestions for developing this approach are offered.

DAVIS, SALLY M. and HARRIS, MARY B.

Adolescents' questions about sex
Journal of Adolescent Health Care, December 1983, 4(4), 225-229

Adolescents from urban and rural areas were given a chance to ask anonymous questions about sex. These questions were then used as the basis for subsequent presentations on sex education. The most popular categories of questions were reproduction, sexuality and contraception, followed by anatomy, venereal disease, pregnancy, abortion, vocabulary, hygiene, cancer and genital discharges. Findings confirm the suggestion that the age and sex of the adolescent be considered in presenting information pertaining to sex. The wide range of responses, from ignorance to sophistication, also suggests that the sex education sessions be tailored to fit the concerns of the specific adolescents involved.

FARROW, JAMES A. and SCHROEDER, ELAINE

Sexuality education groups in juvenile detention
Adolescence, Winter 1984, 19(76), 817-818

Few systematic studies have been conducted which analyze the attitudes toward sexuality and contraception of delinquent adolescents. Despite the assumed high-risk nature of this delinquent population, few juvenile detention facilities have offered systematically evaluated coeducational sex education programs. The current study attempts to develop an

effective coeducational sex education program for this population within a detention facility. This program is specifically designed for a sexually active adolescent group aged 14 to 17.

KLEIN, DANIEL et al.

Achieving sex education program outcomes: points of view from students and alumni

Adolescence, Winter 1984, 19(76), 805-815

A study was undertaken to examine the immediate and long-term impact of secondary school sex education upon program participants. With a Centers for Disease Control study as the criterion for program outcomes, each inventory examined participant changes in knowledge, understanding of self, values, interaction skills, self-esteem, and fear of sex-related activities. The present study supports the notion that positive gains are achieved as a result of each school's sex education program, and these gains remained over time.

NEWCOMER, SUSAN

Does sexuality education make a difference?

New York: PPFA, Education Department, 1985

This paper responds to recent studies that evaluate sexuality education programs in the U.S. and the relationship between education and teenage pregnancy. It reviews the pros and cons which have been debated for years, stating that causal connection between programs and the outcomes are difficult to measure because of other influences in our society on sexual behavior. It concluded that sexuality education is a necessary component but not the only component needed to solve the problem of unintended pregnancies.

OBSTFELD, LISA S. and MEYERS, ANDREW W.

Adolescent sex education: a preventive mental health measure

Journal of School Health, February 1984, 54(2), 68-70

The issue of adolescent sex education as a means of preventing sexuality-related disorders is addressed. Sex education programs are examined in terms of delivery agents, cognitive, attitudinal and behavioral goals and research methodology. Recommendations are made for improving experimental design in sex education research.

PARCEL, GUY S. and COREIL, JEANNINE

Parental evaluations of a sex education course for young adolescents

Journal of School Health, January 1985, 55(1), 9-12

Parents were asked to evaluate their children's participation in a school-based sex education program for young adolescents. They were asked about course objectives, content, materials, expectations, perceived effectiveness, and important outcomes of the instruction. The results indicated parental support for the program, but suggest a paradox, as the parents wanted their children to be informed about sexuality and to be able to make decisions that would avoid problems, but they were uneasy about dealing directly with sexual behavior.

SCALES, PETER and KIRBY, DOUGLAS

Perceived barriers to sex education: a survey of professionals

Journal of Sex Research, November 1983, 19(4), 309-326

This study describes the perceived importance of 165 potential barriers to sex education. A total of 104 professionals actively working as administrators, teachers or evaluators of sex education programs rated the importance of the barriers in restricting or adversely affecting their own sex education programs. The single greatest barrier was the administrators' fear of community opposition. The results of the study are explored in this article in which the authors believe that the most important conclusion to be drawn is that supporters' behavior is as important, if not more important, than opposition efforts in creating a favorable climate for sex education in the community. Although the results are based on perceptions and are only exploratory, they are nevertheless thought-provoking.

SELVERSTONE, ROBERT

Sex education and the adolescent: perspectives from a sex educator
Seminars in Adolescent Medicine, June 1985, 1(2), 145-151

Perceptions on the needs and scope of sexuality education for teenagers are offered. Participation, not only from schools, but from parents and communities is invited, and ways of evaluating sex education programs are discussed.

SIECUS REPORT

Sexuality education in the public schools; a roundtable discussion
SIECUS Report, September 1983, 12(1)

In this special sexuality education issue, people with varying perspectives on sex education share ideas with one another. They all agree that there should be an ongoing family life education program from kindergarten through twelfth grade, with each level of development handled in an appropriate way. In addition to other articles on the subject, an annotated bibliography of curricula, a resource list and book reviews are included.

SONENSTEIN, FREYA L. and PITTMAN, KAREN J.

The availability of sex education in large city school districts
Family Planning Perspectives, January/February 1984, 16(1), 19+

A survey of school districts in cities with populations over 100,000 was conducted in January 1982. Respondents indicated that sex education, in some form, is provided by 80 percent of the districts. The differences in the availability of sex education among elementary, junior and senior high schools are surprisingly small. The survey revealed that in fewer than 10 percent of districts is there serious discussion before the ninth grade of contraceptives or where to obtain them.

TOBIN, JEAN M.

How promiscuous are our teenagers?
British Journal of Family Planning, January 1985, 10(4), 107-112

A detailed sexual history was obtained from 100 teenage girls attending a family planning clinic and followed up for about thirty months. The group was found to have a high continuity rate both with the chosen method of contraception and with their original partner, and a low incidence of unplanned pregnancy or multiple partners. Few problems relating to confidentiality arose, even in the under-16 age group.

CONTRACEPTION

Articles

ABRAMS, MARILYN

Birth control use by teenagers: one and two years postabortion
Journal of Adolescent Health Care, May 1985, 6(3), 196-200

A prospective study was conducted of contraceptive behavior of adolescents following a first-trimester abortion. Each woman had an individual counseling session which included birth control counseling. Effective birth control was used by 77 percent of the 182 respondents one year postabortion and 79 percent two years postabortion. Repeat abortion rates for all respondents were 7 percent the first year and 11 percent the second. The data suggest that teens who have abortions do not rely on them as a method of contraception; instead, they are much more likely to use reliable contraceptive methods postabortion than they were before the unplanned pregnancy.

De PIETRO, ROCCO and ALLEN, RICHARD L.

Adolescents' communication styles and learning about birth control
Adolescence, Winter 1984, 19(76), 827-837

Adolescents have different communication styles for acquiring information about birth control from a mass medium -- interactant or noninteractant, depending on whether they involve communication with others in the process of media use. Three styles of communication are discussed. The noninteractant style identified is a media-oriented style, where the adolescent relies exclusively on the mass media for information. Data suggest that the interactant style is the most beneficial for new learning.

DURANT, ROBERT H. et al.

Influence of psychosocial factors on adolescent compliance with oral contraceptives
Journal of Adolescent Health Care, January 1984, 5(1), 1-6

This paper prospectively tests the influence of a variety of sociomedical and psychosocial factors on compliance with oral contraceptives among adolescent females from a population at high risk for pregnancy. Six factors were found to be significantly associated with noncompliance: multiple sexual partners, appointment being made by the adolescent, low evaluation of personal health, feelings of hopelessness, worry about becoming pregnant, and previous abortion. These findings suggest that certain indicators of sexual activity and social psychological status may help predict noncompliance in some adolescent females.

FAMILY PLANNING PERSPECTIVES

Majority oppose laws restricting teen access to birth control services
Family Planning Perspectives, July/August 1983, 15(4), 197

A poll conducted last spring by Louis Harris and Associates shows that the majority of Americans are opposed to laws that would prohibit birth control services to teenagers who do not have permission from their parents. As a further indication of their attitudes, 85 percent of the poll's respondents said they agreed with the statement that "teenage girls need all the help they can get...to protect themselves from getting pregnant, including birth control assistance from family planning clinics." Describes many of the questions and answers on the survey.

FREEMAN, ELLEN W.

Urban black adolescents who obtain contraceptive services before or after their first pregnancy

Journal of Adolescent Health Care, July 1984, 5(3), 183-190

This paper compares three groups of urban black teenagers at their enrollment in a contraceptive program and at a one-year follow-up. Self-report questionnaires examined attitudes and information about pregnancy and contraceptive use, sources of contraceptive information, sexual and contraceptive experience, family and partner support for contraceptive use, and demographic background factors. Results suggest the need for earlier family involvement in educating and guiding teens together with access to contraceptive services in preventing unwanted adolescent pregnancies.

FURSTENBERG, FRANK F., JR. et al.

Contraceptive continuation among adolescents attending family planning clinics

Family Planning Perspectives, September/October 1983, 15(5), 211+

This study of contraceptive continuation involves 445 adolescents under age 18 who were interviewed at their initial visit to a family planning clinic and at six and fifteen months to collect information on background characteristics, pregnancy, history and contraceptive use. Forty-three percent of teenagers who visited a family planning clinic reported that they always used a contraceptive, and over a 15-month period, they were half as likely as the entire sample to have become pregnant. The primary problem in examining contraceptive patterns among adolescents is one of developing an accurate measure of contraceptive use. This article points out the need for a better yardstick for measuring success and a clearer understanding of what factors contribute to effective use.

HIRSCH, MARILYN B. and ZELNIK, MELVIN

Contraceptive method switching among American female adolescents, 1979

Journal of Adolescent Health Care, January 1985, 6(1), 1-7

Data from the 1979 National Survey of Young Women were used to examine method switching once contraceptive use had begun among 449 never-pregnant young women who reported premarital intercourse more than once. These results suggest that providers and educators should consider the circumstances under which contraceptive methods are chosen and used by young women when counseling them as to what method may be best for them.

HOGAN, DENNIS P., ASTONE, NAN MARIE and KITAGAWA, EVELYN M.

Social and environmental factors influencing contraceptive use among black adolescents

Family Planning Perspectives, July/August 1985, 17(4), 165-169

A survey of black teenagers from Chicago revealed that less than 30 percent of them used a contraceptive at first intercourse. Social class, parents' marital status and neighborhood quality were factors that accounted for statistical differences between boys' and girls' use of birth control; however, these variables seemed to affect contraceptive preparedness at first intercourse only, and not later use of contraception.

HUGGINS, GEORGE R.

Adolescent contraception and informed consent

Female Patient, December 1984, 9(12), 54+

In contraceptive decisions, the adolescent is often torn between her right to privacy and patient-physician confidentiality, and her parents' belief that the minor is their moral

and legal responsibility. The physician can help avoid this dilemma by knowing what the rights of all parties are. Various possible involvements between parents and adolescents regarding contraception are presented. It is the author's belief that parental approval and support may have a marked beneficial effect on an adolescent's ability to use contraception successfully.

KASTNER, LAURA S.

Ecological factors predicting adolescent contraceptive use: implications for intervention
Journal of Adolescent Health Care, April 1984, 5(2), 79-86

Questionnaires concerning areas expected to relate to contraceptive use were completed by 230 female adolescents. The data indicated that positive parent communication about sexuality and a perception of high benefits and low costs associated with contraceptive use were not positively correlated with sexual experience. Implications for the prevention of adolescent pregnancy are discussed.

KISKER, ELLEN ELIASON

The effectiveness of family planning clinics in serving adolescents
Family Planning Perspectives, September/October 1984, 16(5), 212-218

Data from surveys conducted by The Alan Guttmacher Institute in 1981 have been used to create three indicators of effectiveness of family planning clinics in serving teenagers: the mean delay between first intercourse and first clinic visit; teenage patient retention; and the average excess of patient satisfaction over dissatisfaction with clinic policies and services. An evaluation and ways clinics can improve their services to teens are explored in this paper.

KISKER, ELLEN ELIASON

Teenagers talk about sex, pregnancy and contraception
Family Planning Perspectives, March/April 1985, 17(2), 83-90

A series of groups of 16- to 19-year-old teenagers were interviewed about their knowledge and use (or, more frequently, non-use) of contraception and of sex, pregnancy, abortion, and sex information sources. The discussions highlight significant obstacles to consistent and effective contraceptive practice among teenagers: social values that denigrate contraceptive preparedness; poor communication with parents and partners; inadequate factual information from peers; great discomfort and embarrassment in sexuality and birth control; an overwhelming need for privacy about sex and birth control; little awareness in males about their legal responsibilities for out-of-wedlock births; poor understanding of many of the most effective birth control methods; and negative feelings about family planning clinics and doctors.

NAMEROW, PEARILA BRICKNER, PHILLIBER, SUSAN GUSTAVUS and HUGHES, MARILYN

Follow-up of adolescent family planning clinic users
Family Planning Perspectives, July/August 1983, 15(4), 172-176

A well planned follow-up system for adolescents attending a hospital-based contraceptive clinic in New York City is discussed. The utility of such a system in improving the delivery of contraceptive services to young people is also documented. It is concluded that in spite of the need for confidentiality, clinic efforts seem to demonstrate the feasibility of a vigorous follow-up system for contacting those who have missed a contraceptive appointment.

NATHANSON, CONSTANCE A. and BECKER, MARSHALL H.

The influence of client-provider relationships on teenage women's subsequent use of contraception.

American Journal of Public Health, January 1985, 75(1), 33-38

The subjects for the study are 2,900 eligible clients making their first contraceptive visit and 338 clinic staff nurses in 78 clinics. Results of interviews demonstrate that client and staff expectations and interactions are significant predictors of adherence to a contraceptive regimen; under circumstances where clients anticipate, and staff employ, authoritative guidance in helping the clients to select a contraceptive method, clinic mean levels of contraceptive use are substantially increased.

ORR, MARGARET TERRY

Private physicians and the provision of contraceptives to adolescents

Family Planning Perspectives, March/April 1984, 16(2), 83-86

Approximately 90 percent of the private physicians surveyed are willing to help sexually active adolescent women obtain contraceptive services either by providing the services themselves or by referring such patients to another source of care. However, fewer than 60 percent will serve an unmarried minor on her own consent. Teenagers prefer family planning clinics to private physicians because: they think the physician would tell their parents; they do not know of a physician who would prescribe contraceptives; a greater variety of methods is available from clinics; and, private physicians are more expensive than clinics.

POLIT-O'HARA, DENISE and KAHN, JANET R.

Communication and contraceptive practices in adolescent couples

Adolescence, Spring 1985, 20(77), 33-43

Eighty-three stable, sexually active adolescent couples were surveyed on the extent of their communication about and actual practice of birth control. Most couples had discussed contraception at least once, but usually after their first intercourse together. Couples with good communication patterns were most likely to practice effective contraception; the respondents who felt that contraception had not been adequately discussed were most likely to experience an unintended pregnancy.

SHEA, JUDY A. et al.

Factors associated with adolescent use of family planning clinics

American Journal of Public Health, November 1984, 74(11), 1227-1230

This study reviewed clinic records of 498 adolescent family planning clients to document clinic use patterns. For a subsample of 359 adolescents, relationships were explored between clinic use and contraceptive use, demographic characteristics, social relationships, and contraceptive attitudes. Results of the study are presented. The single significant correlate of regular clinic use was the adolescents' satisfaction with their contraceptive methods. Service providers should ensure that adolescents select a suitable contraceptive method and closely follow those whose clinic use patterns deviate from standard protocols.

TYRER, LOUISE B.

Oral contraception for the adolescent

Journal of Reproductive Medicine, July 1984, 29(7), Supplement, 551-559

The data on the use of various contraceptive methods by adolescent women show the Pill to be the first choice. Noncontraceptive health benefits of oral contraceptive use is an excellent reason for prescribing the Pill for young women who are sexually active. It is important to screen adolescents carefully for contraindications to Pill use prior to initial prescription plus frequent follow-up and monitoring so as to minimize side effects and maximize compliance and continuation of use.

VAN DEN BERG, BEA J. and PARRY, MARIAN A.

Adolescents' preference of source to obtain contraceptive information

American Journal of Obstetrics and Gynecology, November 15, 1983, 147(6), 719-721

A recent study of almost 2,000 adolescents included an interview which contained a question regarding the place or person to whom the adolescent would go for information on pregnancy prevention. The data suggest that even if family relationships are favorable, the majority of adolescents intend to seek advice on conception and contraception primarily outside of the family. It places the responsibility on society to promote access to professional advice rather than to put roadblocks in the way.

ZELNIK, MELVIN, KOENIG, MICHAEL and KIM, YOUNG J.

Sources of prescription contraceptives and subsequent pregnancy among young women

Family Planning Perspectives, January/February 1984, 16(1), 6+

Teenagers who get a prescription contraceptive before they begin having sex or after consistent use of a nonprescription method are least likely to get pregnant afterwards, whether they get their prescription method from a clinic or a doctor. This analysis indicates that the main factors determining which source the young women chose were race and age at first use of a prescription method.

PARENTHOOD

Books

ADOLESCENT PARENTHOOD, Max Sugar, ed. New York: SP Medical & Scientific Books, 1984. 237 p. \$29.95. 82-21610; ISBN 0-89335-185-7.

In this creative approach to the topic of adolescent parenthood, the authors utilize a combination of several approaches: consideration of fictional characters in history, astute clinical observations, reviews of the literature, and their own investigation. The book is divided into four sections that deal with the adolescent and extended family, the infant and its developmental risks, some current programs for adolescent parents, and the implications for programs.

Articles

BURT, MARTHA R. and SONENSTEIN, FREYA L.

Planning programs for pregnant teenagers

Public Welfare, Spring 1985, 43(2), 28-36

The increasing numbers of pregnant adolescents and teenage mothers have placed growing demands on state human services departments and welfare agencies. As programs gear up to meet the needs of these girls, human services directors have begun to seek guidance in

designing coordinated and effective methods for delivering these services. Data from 21 federally-funded care programs established in 1982 for pregnant and parenting teens by the Office of Adolescent Pregnancy Programs, DHHS have been collected here to provide guidelines for the provision of appropriate support for teen parents.

CHILDREN'S DEFENSE FUND

Preventing children having children

Children's Defense Fund, Clearinghouse Paper no. 1, 1985

Summarizes the problem of teenage pregnancy and presents strategies for its prevention. Highlights issues of special concern, including pregnancy among black teens, very young teen mothers, out-of-wedlock births, reaching male teens, and more.

CHILMAN, CATHERINE S.

Feminist issues in teenage parenting

Child Welfare, May/June 1985, 64(3), 225-234

The plight of unmarried teenage parents has become a source of great popular concern. Sexism particularly afflicts programs and policies for these young women, as well as the behaviors that lead up to their becoming unmarried parents: nonmarital coitus, failure to use effective contraceptives consistently, nonuse of abortion, decisions not to place the child for adoption, and decisions not to marry.

FAMILY PLANNING PERSPECTIVES

Substantially higher morbidity and mortality rates found among infants born to adolescent mothers

Family Planning Perspectives, March/April 1984, 16(2), 91-92

Infants born to mothers younger than 18 and to mothers aged 18-19 who have already had a child have substantially higher morbidity and mortality rates than infants born to other mothers. Babies born to these mothers are at risk because of low birth weight and socioeconomic disadvantages.

FORD, KATHLEEN

Second pregnancies among teenage mothers

Family Planning Perspectives, November/December 1983, 15(6), 268-269+

National data is presented on the contraceptive practice of teenage mothers, pregnancy rates in the year following their first birth and the planning status of those pregnancies. Data are shown by race, age at first birth, income level and marital status. The findings show that most teenage mothers who were sexually active did use a contraceptive method. The pill was the most popular choice. Black and low-income mothers were less likely than white and higher income mothers to use a contraceptive method. Regardless of socioeconomic or marital status, most second pregnancies occurred among women who were not using a contraceptive method and were not trying to become pregnant.

LANDY, SARAH et al.

Teenager pregnancy: family syndrome?

Adolescence, Fall 1983, 18(71), 679-694

A study was conducted to explore selected psychosocial characteristics of fourteen teenage mothers aged sixteen years or younger. The current predominant view is that the unmarried mother is motivated by psychological determinants or unresolved parent-child rela-

tionships. The study suggests that there is a specific family syndrome which increases the likelihood of early teenage pregnancy. Such families are characterized by a weak or absent father and a dominating overprotective mother with whom a close symbiotic relationship is established.

MAKINSON, CAROLYN

The health consequences of teenage fertility

Family Planning Perspectives, May/June 1985, 17(3), 132-139

The literature on the health consequences of teenage fertility indicates that increased risks of maternal complications are often associated more with socioeconomic factors than with the biological effects of age. However, lack of prenatal care is a major cause of pregnancy-related complications in younger mothers, and there is a marked association between maternal youth and low birth weight, prematurity, and late fetal death. There is no evidence of increases in congenital malformations among the infants of teenagers.

MILLER, SHELBY H.

Childbearing and childrearing

Children Today, May/June 1984, 13(3), 26-29

This article is based on the author's book Children as Parents; Final Report of a Study of Childbearing and Child Rearing Among 12- to 15-Year-Olds (New York: Child Welfare League of America, 1983). The study investigates how younger teenagers differ from older ones in their abilities to bear and raise healthy children and deal with the competing demands of being parents and teenagers at the same time. Information about several programs is included.

MILLER, SHELBY H.

The relationship between adolescent childbearing and child maltreatment

Child Welfare, November/December 1984, 63(6), 553-557

Reported here are findings from a secondary analysis of data collected in the National Study of the Incidence and Severity of Child Abuse and Neglect. The findings parallel the general public opinion that teenage mothers are more likely to maltreat their children. The finding that the children of teenage mothers are the most likely to be physically neglected means that specific services, such as material items like food and baby clothing, and close supervision of medical care through home health care visits, need to be provided.

MOORE, KRISTIN A. and WERTHEIMER, RICHARD F.

Teenage childbearing and welfare: preventive and ameliorative strategies

Family Planning Perspectives, November/December 1984, 16(6), 285-289

Teenage mothers are disproportionately represented among welfare recipients. Computer-simulation strategies have been developed to illustrate preventive and ameliorative scenarios to help reduce this problem.

MOTT, FRANK L. and MARSIGLIO, WILLIAM

Early childbearing and completion of high school

Family Planning Perspectives, September/October 1985, 17(5), 234-237

Teenagers who give birth while in high school or soon after leaving school are far less likely to eventually graduate from high school (with a regular diploma or equivalency certificate) than are women who delay childbearing until their early 20s.

MUSICK, JUDITH S., HANDLER, ARDEN and WADDILL, KATHERINE DOWNS

Teens and adoption: a pregnancy resolution alternative?

Children Today, November/December 1984, 13(6), 24-30

Over the past 20 years, fewer teenage mothers have been giving up their babies for adoption. Availability of abortions, a sense of responsibility for their infants, and greater parental support are cited as reasons, as well as peer pressure from cliques and from boyfriends. The difficulty of finding adoptive homes for Black, Hispanic and mixed-race babies also explains why many of these girls are reluctant to part with their infants.

OSOFSKY, HOWARD J.

Mitigating the adverse effects of early parenthood

Contemporary Ob/Gyn, January 1985, 25(1), 57+

1.2 million teenage girls become pregnant each year in the U.S., and obstetricians caring for them must be aware of the special medical problems of younger mothers. These include anemia, UTIs, eclampsia, hypertension, and a host of other problems, not to mention the problems faced by their infants: greater chances of premature birth, low birth weight and greater rates of morbidity and mortality. Guidelines are provided for clinicians to help alleviate some of these difficulties.

RESNICK, MICHAEL D.

Studying adolescent mothers' decision making about adoption and parenting

Social Work, January/February 1984, 29(1), 5-10

In light of the interest shown by the Reagan Administration in the sexual, parenting, and adoption behavior of adolescent mothers, the author examines existing studies on adolescents' decision making about placing their babies for adoption and proposes some theoretical and methodological considerations to guide future investigations in this area.

SHERLINE, DONALD M.

When the mother is a child herself

Contemporary Ob/Gyn, December 1984, 24(6), 83+

Analysis of the effects of extreme youth on pregnancy complications, delivery results, and neonatal status seems to indicate that it is less important than sociological factors. The younger the pregnant adolescent, the more dependent she is on resources of family and community. She is unlikely to have a stable relationship with the father of the child; she will need guidance on nutrition, drugs, smoking, and contraception; she will need encouragement in school and constant reinforcement of her self-image. She will need to be taught child care and helped through the maze of overlapping agencies. It is clear that a comprehensive approach is needed.

SMITH, PEGGY B. et al.

A curriculum for adolescent mothers: an evaluation

Journal of Adolescent Health Care, May 1985, 6(3), 216-219

One hundred four indigent, pregnant adolescents were selected to evaluate the effect of a prenatal education curriculum presented at a maternity clinic. The girls were visited 6 months postpartum by social workers to determine whether short-term, intermediate and long-term curriculum content items were effectively remembered. Success with short-term and intermediate content items (health care and child-rearing techniques) was moderate; long-term items (educational and vocational activities) did not appear to be well retained.

VUKELICH, CAROL and KLIMAN, DEBORAH S.

Mature and teenage mothers' infant growth expectations and use of child development information sources

Family Relations, April 1985, 34(2), 189-196

Groups of teenage and mature mothers were compared to assess their knowledge or expectations of infant growth and development and to determine the sources they were likely to use to obtain this information. Mothers' age, education and type of occupation affected both their expectations for infant development and their sources of information on it; mature mothers relied mostly on books or magazines, while teenager mothers relied most heavily on family. There is also a substantial body of knowledge that none of these mothers possessed; implications for parent educators are discussed.

COMMUNICATION WITH PARENTS

Books

I WISH MY PARENTS UNDERSTOOD: A REPORT ON THE TEENAGE FEMALE, Leslie Jane Nonkin. New York: Freundlich Books, 1985. 268 p. \$14.95. LCCN 84-26031; ISBN 0-88191-018-X.

Based on a three-year study supported by TeenAge Magazine's survey of teenage relationships, this book combines statistical research with interviews with American teenage girls, probing their feelings about sex, virginity, success, religion, manners, beauty, parents, peer pressure, and more. The author uses five categories to describe teenage girls' outlooks on life: Twentieth-Century Fast Trackers, Sweet Southern Belles, Modern Traditionalists, Supersonic Daters and Strong Individualists. A section on teenagers' expectations of sex, use (and non-use) of birth control and pregnancy may be helpful for any educator or counselor working with adolescents.

NO IS NOT ENOUGH: HELPING TEENAGERS AVOID SEXUAL ASSAULT, Caren Adams, Jennifer Fay and Jan Loreen-Martin. San Luis Obispo, Calif.: Impact Publishers, 1984. 177 p. \$6.95. 84-20506; ISBN 0-915166-35-6.

This work answers the toughest questions about teenage sexual assault, acquaintance rape, and exploitation. Intended for parents to help in talking with teenagers about sexual assault, the book tells how parents can help protect teenagers from sexual assault and exploitation. Teens need enough information to be able to recognize when situations are developing that might lead them to being exploited, abused, or pushed into sexual contact before they are ready. It is necessary to talk to sons as well as daughters and to focus on acquaintances as well as strangers. The authors also address attitudes which perpetuate sexual violence in our society.

Articles

AVED, BARBARA M. and LOBDELL, GEORGE W.

Parent-child communication about sexuality; the physician as community educator
Journal of Adolescent Health Care, October 1984, 5(4), 292-293

The authors stress the importance of educating adolescents about sexuality and family planning before they become sexually active. Sex education efforts by physicians as well

as parents may make a significant contribution toward reducing the incidence of early unintended pregnancy. In a recent large, family communication program, results appear to support the authors' contention that the physician's advocacy role in sex education is important. The project is described briefly.

CASEY, SEAN and PETERSON, LYNN

Sex education for parents

Children Today, July/August 1985, 14(4), 11-15

Parents are the main providers of sexuality education for their children, and many feel inadequately prepared for that role. Accurate, sensitive training in reproductive biology and sexuality issues for parents may dissipate fear and embarrassment and create closer bonds between them and their children. Several parent-education programs are described.

FURSTENBERG, FRANK F., JR. et al.

Family communication and teenagers' contraceptive use

Family Planning Perspectives, July/August 1984, 16(4), 163-170

In an attempt to test the relationship between contraceptive use and communication about sex and birth control between parents and their children, 290 adolescents were interviewed at family planning clinics. Results showed that family communication about these topics appeared to count for very little with regard to levels of contraceptive use among sexually active teenagers.

JACKNIK, MICHELE et al.

OCTOPUS -- a church-based sex education program for teens and parents

Adolescence, Winter 1984, 19(76), 757-763

OCTOPUS is the acronym for a rural, church-based sex education program for teens and parents. The tentacles symbolize the agencies and individuals involved in this multi-faceted community outreach program designed to promote "Open Communication Regarding Teenagers, Or Parents, Understanding of Sexuality." Its purpose was to establish a forum for family discussion within a church setting to enhance communication skills, convey factual information, and cultivate the development of a decision-making process to help parents help their teenagers acquire appropriate morals and values.

KEIFFER, ELIZABETH

What kids really want to know about sex but are afraid to ask

Family Circle, April 17, 1984, 97(6), 22+

After months of sitting in on teenage rap sessions, the ten most intimate questions teens wish they could discuss with their parents were identified. The current state of parent-teen communication about sex is discussed as well as suggested ways of talking about sex and how to answer the questions posed.

NEWCOMER, SUSAN F. and UDRY, J. RICHARD

Mothers' influence on the sexual behavior of their teenage children

Journal of Marriage and the Family, May 1984, 46(2), 477-485

The influence of mothers' sexual experiences as teenagers on their teenage children's current sexual behaviors is examined. Findings indicate that there is an influence, but not much of this influence is transmitted via the differential attitudes, communication

patterns or behavioral control attempts of mothers with differing early sexual experience. For girls there is reason to believe that the correlation is transmitted partly via their biological relationship.

NEWCOMER, SUSAN F. and UDRY, J. RICHARD
Parent-child communication and adolescent sexual behavior
Family Planning Perspectives, July/August 1985, 17(4), 169-174

Data collected from over 500 teenagers and their mothers indicate that neither parental attitudes toward premarital sex nor parent-child communication about sex and contraception appear to affect teenagers' subsequent sexual and contraceptive behavior, despite widespread hopes to the contrary. Teens are often ignorant of their parents' attitudes on sexual issues, and they and their parents often contradict one another in describing the kinds of sex-related conversations they have had.

RIDDLE, PATRICIA K.
Helping parents become sex educators
Children Today, January/February 1984, 13(1), 9-11

The education staff of a local family planning agency, in response to requests from community organizations, developed a sexuality education program for puberty-age youngsters. Geared for 4th to 8th grade children and their parents, this program is designed to facilitate communication about sexuality issues. Parents' participation is mandatory, thereby allowing for the communication and learning process to continue at home. The program serves as a catalyst for ongoing discussion between children and parents.

REPRODUCTIVE HEALTH

Articles

BROWN, MARIE ANNETTE
Adolescents and abortion: a theoretical framework for decision making
JOGN Nursing, July/August 1983, 12(4), 241-247

Beach and Mitchell's decision-making model is presented to explain the process of adolescent decision making to continue or terminate a pregnancy. Adolescent developmental issues are discussed in relation to the pregnancy/abortion decision. Implications for nurses counseling pregnant adolescents are presented.

BURKMAN, RONALD T., ATIENZA, M.F. and KING, T.M.
Morbidity risk among young adolescents undergoing elective abortion
Contraception, August 1984, 30(2), 99-105

A cohort study comparing risks of morbidity at the time of elective abortion between 399 young adolescents aged 17 years or less matched to 399 women aged 20 to 29 years was completed. The study matched for duration of gestation, types of procedure, parity, race, month of procedure, and insurance status. Results indicated a higher risk of post-abortal endometritis for adolescents compared to older women.

HAMMERSCHLAG, MARGARET R.
Sexually transmitted diseases in children and adolescents
Medical Aspects of Human Sexuality, July 1984, 18(7), 77-83

The increasing incidence of sexually transmitted diseases (STDs) in children and adolescents relates to an increase in sexual abuse or the recognition of sex abuse in children and to increased sexual activity in teenagers. Although most studies of STDs in children and adolescents have concentrated on gonorrhea and syphilis, these young people are at risk for acquiring the other venereal infections that are prevalent in the adult population, such as chlamydia.

JOURNAL OF ADOLESCENT HEALTH CARE

Adolescents and sexually transmitted diseases: an expanding problem

Journal of Adolescent Health Care, July 1985, 6(4), 257-327

This issue contains papers by different authors dealing with various aspects of teenagers and sexually transmitted diseases. Pelvic inflammatory disease, homosexual adolescents, and the attempt to have adolescents postpone sexual involvement are among the topics discussed. Also included are a bibliography on teenagers and STDs, a resource list, and information about STD prevention/ training clinics.

LITT, IRIS F. and CUSKEY, WALTER R.

Satisfaction with health care; a predictor of adolescents' appointment keeping

Journal of Adolescent Health Care, July 1984, 5(3), 196-200

The purpose of the study was to explore patient satisfaction among teenagers and its relationship to appointment keeping. The patient's satisfaction was highly correlated with subsequent compliance in coming for appointments. Satisfaction, and therefore appointment keeping, was higher in females, older adolescents, those making their own initial clinic appointment, those with a positive body image, and those scoring high on a test of personal freedom.

MILLSTEIN, SUSAN G., ADLER, NANCY E. and IRWIN, CHARLES E., JR.

Sources of anxiety about pelvic examinations among adolescent females

Journal of Adolescent Health Care, April 1984, 5(2), 105-111

Sources of anxiety about pelvic examinations were examined in 84 female adolescents seen in an adolescent clinic. Common concerns about the examination, sources of information about the pelvic exam, and anxiety prior to, during, and following the pelvic exam were all included. The concern most highly associated with anxiety was fear of pain.

MORIN-GONTHIER, MARIETTE and LORTIE, GILLES

The significance of pregnancy among adolescents choosing abortion as compared to those continuing pregnancy

Journal of Reproductive Medicine, April 1984, 29(4), 255-259

The significance of pregnancy for adolescent women varies greatly. Psychosocial status, contraceptive and sexual habits, attitudes towards pregnancy, and environmental influences were studied in 50 teenagers who chose abortion. These young women were matched for age and parity with a control group of 50 who elected to carry their pregnancies to term. The results point to significant differences between the two groups.

NELSON, MARY

Talking with your daughter about her first pelvic exam

Family Life Educator, Spring 1985 3(3), 11-13

A young woman's first pelvic examination can often be a fearful experience, but parents

can do much to make it more tolerable by explaining what to expect and by helping her to keep a positive attitude about her body and her health. Written for both young women and parents, a routine gynecologic exam is described.

PHILLIPS, SHERIDAN

Gonorrhea in adolescents

Medical Aspects of Human Sexuality, April 1984, 18(4), 74+

Gonorrhea as a major adolescent health problem is explored. The rise in gonorrhea among teenagers reflects adolescents' attitudes, behavior, and knowledge regarding sexual activity. Diagnosis and management, as they relate specifically to adolescents, are presented.

PRICE, JAMES H., DESMOND, SHARON and KUKULKA, GARY

High school students' preceptions and misperceptions of AIDS

Journal of School Health, March 1985, 55(3), 107-109

This study examines the knowledge, beliefs, and sources of information of high school students concerning AIDS. They were found to have a very limited knowledge of the disease; males were more knowledgeable about it than females, but the majority of students were not personally worried about contracting it. The primary sources of AIDS information were television, newspapers, magazines and radio; schools were one of the least-cited sources of information.

SCHAFF, ERIC A.

Adolescent and adult females with pelvic inflammatory disease in an ambulatory setting

Journal of Adolescent Health Care, December 1983, 4(4), 251-256

A retrospective chart review was conducted of all patients with pelvic inflammatory disease (PID) during 1980 at an inner-city neighborhood health center. The presenting clinical features, laboratory results, management and recurrences within a 6-18 month follow-up were analyzed. The majority were treated as outpatients with a course of ampicillin. Over one-fourth had a recurrence. An effective antibiotic regimen and the treatment of all male contacts should reduce the recurrence rate.

SENANAYAKE, PRAMILA

Problems of adolescent sex

International Journal of Gynaecology and Obstetrics, December 1984, 22(6), 457-461

Counseling needs of teenagers, risks of STDs, contraception for adolescents and the consequences of pregnancy in adolescence are reviewed in terms of their effects on the teenager as an individual and on his/her community. The need for services specifically designed for teenagers is stressed, demonstrating that many of the "problems" of adolescent sex can be successfully addressed through well-designed and executed programs.

SILBER, THOMAS J. and NILAND, NONA F.

The clinical spectrum of syphilis in adolescence

Journal of Adolescent Health Care, April 1984, 5(2), 112-116

Syphilis is often overlooked by adolescent patients. To investigate how syphilis first appears, this study reviewed the medical history of 33 patients. The results indicate that those caring for adolescents should maintain a high index of suspicion for this disease.

SILBER, TOMAS J.

Some medical problems common in adolescence.

Medical Aspects of Human Sexuality, February 1985, 19(2), 79+

There are about 20 million teenagers in the U.S., and adolescent medicine has become an important area of research. Three medical problems are particularly common in teenagers: variations in growth and maturation (which can be particularly agonizing as teens worry about being "abnormal"); adolescent gynecomastia (exaggerated breast development in boys); and varicocele (uneven testicular growth). Symptoms and treatment for all of these problems are given.

TOBIN, JEAN M. and ROY, R. BASU

Are we failing our teenagers? Value of a family planning service for teenagers within the sexually transmitted disease clinic

British Medical Journal, February 2, 1985, 290(6465), 376-378

One hundred teenage girls attending an STD clinic were surveyed on their use of contraceptives. About three-quarters of them used reliable birth control methods; the remainder did not, and were urged to do so as they were at high risk of having unplanned pregnancies. Ready availability of contraceptive advice for unprotected teenagers in STD clinics would greatly reduce this risk.

WEINSTEIN, ALLAN J.

Sexually transmittable diseases and other genital infections during adolescence

Journal of Reproductive Medicine, June 1984, 29(6), 411-415

The incidence of sexually transmitted diseases (STDs) has increased in recent years, and a high proportion of the patients are adolescents. After an epidemiological overview, the author examines the following STDs: gonorrhea, syphilis, nongonococcal urethritis, vaginitis, herpes, and pelvic inflammatory disease. A study has indicated that there is a critical need for education about STDs and about effective methods of preventing it.

WITZIG, DIANE K. and OSTWALD, SHARON K.

Knowledge of toxic shock syndrome among adolescent females: a need for education

Journal of School Health, January 1985, 55(1), 17-20

High school girls were surveyed to determine the relationship between their choices of menstrual products and their knowledge of toxic shock syndrome. Their knowledge of TSS was largely inaccurate and fragmented, and no significant relationship was found between this and their choice on napkins or tampons. Results of the study are discussed in terms of the implications for the health of adolescent girls, and recommendations for using health professionals, parents and the media in developing TSS education programs are offered.

SEXUAL BEHAVIOR

Books

SEX AND THE AMERICAN TEENAGER, Robert Coles and Geoffrey Stokes. New York: Rolling Stone Press, 1985. 238 p. \$5.95. 84-48147; ISBN 0-06-096002-7.

Based on a survey of over 1,000 teenagers, the authors explore the attitudes and practice by young Americans of sex, contraception, oral sex, romance, courtship and marriage, in

light of their own erotic desires and moral values. Both analysis of trends and interviews with teenagers are included. This book is a companion volume to an HBO television special of the same name.

Articles

BILLY, JOHN O.G. and UDRY, J. RICHARD

The influence of male and female best friends on adolescent sexual behavior
Adolescence, Spring 1985, 20(77), 21-32

The authors studied the extent to which adolescents' same-sex and opposite-sex best friends influence their sexual behavior. There is apparently little influence of friends on black males or females, or on white males; however, white females are greatly influenced by the sexual behavior of their best male and female friends, and are most likely to experience a first sexual intercourse within two years of their friends.

CHRISTOPHER, F. SCOTT and CATE, RODNEY M.

Anticipated influences on sexual decision-making for first intercourse
Family Relations, April 1985, 34(2), 265-270

The basic factors that virgins perceive will influence them in their decision to engage in their first act of coitus were investigated. A survey of 195 college students revealed three anticipated influence factors: physical arousal, relationships, and circumstances. Males and females differed in their responses to the various factors.

EBERHARDT, CAROLYN A. and SCHILL, THOMAS

Differences in sexual attitudes and likeliness of sexual behaviors of black lower-socioeconomic father-present vs. father-absent female adolescents
Adolescence, Spring 1984, 19(73), 99-105

This study compared sexual permissiveness attitudes and likely behaviors of father-absent vs. father-present black, lower-socioeconomic female adolescents. There were no differences in sexually permissive behavior between the two groups. Comparisons to previous research on this subject are made and the clear need for further research is stated.

HERJANIC, BARBARA

How adolescents can deal with pressures to engage in sex
Medical Aspects of Human Sexuality, June 1984, 18(6), 204+

Preparation for meeting pressures to engage in sex should begin in preadolescence, before there is much chance of peer talk or experimentation. The author gives illustrations of a variety of ways in which a physician can open discussion about sexuality with a young patient at the time of an annual physical examination. Reasons why boys as well as girls engage in sexual activity when they really do not want to are presented.

HOWARD, MARION

How the family physician can help young teenagers postpone sexual involvement
Medical Aspects of Human Sexuality, June 1985, 19(6), 76-87

Physicians often see the harmful effects of teenage sexual involvement: pregnancy, abortion, sexually transmitted diseases, child abuse, and more. Many wish they could do more to help young people postpone sexual activity. Suggestions are given for doctors to talk

light of their own erotic desires and moral values. Both analysis of trends and inter- This study questions the findings of most research claiming that teenage pregnancies are generally unwanted, unplanned and unintended. It was found that sentiments of "love" were associated with becoming pregnant more than with starting sexual activity. These findings suggest that more research needs to be directed at the development of affective bonds with and the aspirations for marriage to the sex partners. Such research may explain why these teenagers put themselves at risk.

ZABIN, LAURIE S. et al.

Adolescent sexual attitudes and behavior: are they consistent?
Family Planning Perspectives, July/August 1984, 16(4), 181-185

Relationships between sexual attitudes and behavior among adolescents were studied in data collected by self-administered questionnaires from approximately 3,500 junior and senior high school students. An analysis of the results are presented. While there is frequently a statistical relationship between the expressed attitude and associated behavior, there is a large minority in each area for whom the behavior and the attitude are clearly at variance.

ZABIN, LAURIE SCHWAB

The association between smoking and sexual behavior among teens in U.S. contraceptive clinics
American Journal of Public Health, March 1984, 74(3), 261-263

A study of teenage women in 32 contraceptive clinics in the U.S. shows a strong negative relationship between age of first intercourse and the level of cigarette smoking. Also indicated is a higher level of cigarette smoking among young women with lower levels of contraceptive usage, or usage of less effective methods.

SCHOOL-BASED PROGRAMS

Articles

COOKE, GWEN and WALLACE, HELEN

The California statewide family health education and training program 1981-1982
Journal of School Health, March 1984, 54(3), 118-121

The philosophy of the Family Health Education and Training Program rested on a belief in the ability of home, church, school and community and health care provider to work together at the local community level to develop Family Life Education programs that are consistent with community standards and responsive to student needs. This paper describes some of the findings of a study of the ninth and tenth grades, as well as the details of methodology of all the components of the statewide program.

DELATTE, JOSEPH G. et al.

Project SCAN: counseling teenage parents in a school setting
Journal of School Health, January 1985, 55(1), 24-26

A 3-year interdisciplinary intervention program with adolescent parents and expectant parents was conducted in a public school system, and combined educational and counseling efforts within a regular curriculum to provide information, support and the chance for personal growth. There is evidence that the program was effective in keeping the students in school; significantly more program members remained in school than control group members.

DRYFOOS, JOY

School-based health clinics: a new approach to preventing adolescent pregnancy?
Family Planning Perspectives, March/April 1985, 17(2), 70-75

In a growing number of American communities, comprehensive health services -- including family planning services -- are being offered in clinics located in or near public high schools and junior high schools. Fourteen such programs in 32 schools are described here. School-based clinic programs have been credited with improving students' health, lowering their birthrates, raising their levels of contraceptive use, and improving their school attendance. Low-income students reap the most benefit from these programs. However, there have been few reliable studies of the programs, and improved program evaluation will be useful in helping these clinics retain their financial and community support.

KLEIN, DANIEL

Knowledge, attitude and behavioral changes as a result of sex education
Journal of Sex Education and Therapy, Spring/Summer 1984, 10(1), 26-30

The continued impact of a sex education program, regarding self-reported changes in knowledge, attitudes and behaviors, was investigated by means of a questionnaire. Samples were drawn from a Midwestern high school identified as having an outstanding sex education program. Overall results indicated positive views from the respondents with respect to the program's impact on their lives.

ONYEHALU, ANTHONY S.

Inadequacy of sex knowledge of adolescents: implications for counseling and sex education
Adolescence, Fall 1983, 18(71), 627-630

There is abundant evidence that indicates a serious lack of sexual knowledge by the average adolescent across cultures. Investigations have demonstrated that sex learning, generally colored with misconceptions and misinformation, is obtained almost entirely from the peer group. This article suggests that in order to avoid or control premature teenage pregnancy, a comprehensive program of sex education and sex counseling for boys and girls in the second decade of the life cycle is overdue.

SCHMIDT, ANN V.

Teenage mothers
Children Today, July/August 1985, 14(4), 16-18

A high-school-based infant care center for teenage mothers in northern Virginia is described. The program, for mothers aged 14-18, teaches adolescents child-care skills and provides day care for their infants, giving mothers a chance to finish high school and earn diplomas.

TAYLOR, BARBARA et al.

School-based prenatal services: can similar outcomes be attained in a nonschool setting?
Journal of School Health, October 1983, 53(8), 480-486

The purpose of this study is to evaluate whether enhancement of hospital-based prenatal care of adolescents results in pregnancy outcomes comparable to those found in adolescents receiving care at school-based clinics. An initial study comparing hospital clinic and school clinic programs indicated that delivered teens from the high school clinics had earlier and more frequent prenatal visits and fewer low birth weight babies than delivered

adolescents who received care at hospital based clinics. A follow-up study was conducted, using criteria similar to the previous study, to compare the results of hospital and school-based programs for pregnant teens. In comparing the results of the two studies, it is evident that major improvements in a nonschool clinic site can enhance patient outcomes.

ZABIN, LAURIE SCHWAB et al.

A school-, hospital- and university-based adolescent pregnancy prevention program; a cooperative design for service and research

Journal of Reproductive Medicine, June 1984, 29(6), 421-426

A program was designed to reduce the incidence of early childbearing among a high-risk, inner-city junior and senior high school population. This paper reports levels of sexual activity, contraceptive use, and pregnancy in the student population, using data from anonymous, self-administered questionnaires, and outlines the program's objectives and major features. It also suggests variables that can be used in the measurement of program impact.

TEENAGE LIFE IN GENERAL

Books

HEALTH CARE OF THE FEMALE ADOLESCENT, Sharon Golub, ed. New York: The Haworth Press, 1984. 141 p. \$19.95. 84-4560; ISBN 0-86656-298-2.

The contributors offer their knowledge and insight about the health problems adolescents commonly encounter and ways in which to prevent or treat them. The importance of psychological factors and risk taking behaviors is stressed as well as prevention and health education. This work would be useful to educators, nurses, physicians, psychologists, and others who work with adolescents.

HOW TO SURVIVE YOUR ADOLESCENT'S ADOLESCENCE, Robert C. Kolodny et al. Boston: Little, Brown & Co., 1984. 350 p. \$17.95. 84-9702; ISBN 0-316-50158-1.

The authors break down the components that contribute to "positive parenting" in this comprehensive handbook on dealing with adolescents. They deal with nurturing, preventive strategies, crisis solving, self-awareness and awareness of the teen, role models, and parent-child communication. Specific topics such as sex, drugs, social skills, and school are explored along with many others.

TEENAGERS THEMSELVES, Glenbard East Echo, comp. New York: Adama Books, 1984. 271 p. \$16.95. 83-26568; ISBN 0-915361-04-3.

Thousands of high school students across the country participated in this work, compiled by the Glenbard East Echo, a weekly high school paper published by the Glenbard East High School in Lombard, Illinois. In first person accounts, these teenagers describe their feelings about sex, parents, divorce, families, drugs, religion and other beliefs, prejudice, violence, work and the future.

TEENS LOOK AT MARRIAGE: RAINBOWS, ROLES, AND REALITIES, Jeanne Warren Lindsay. Buena Park, California: Morning Glory Press, 1984. 256 p. \$9.95. 84-18954; ISBN 0-930934-15-6 (pbk.)

This book offers adults a look into the real world of teenage couples, a world of poverty, three-generational living, jealousy, early parenthood, and for a few, the beginning of a long-term satisfying relationship based on trust, respect and caring. The author explores the attitudes toward marriage of more than 3,000 teenagers from across the country. The goal of this work is to assist professionals and other caregivers in understanding the world of teenagers who settle into a relationship, often before they have developed their own identities.

Articles

BASSOFF, BETTY Z. and ORTIZ, ELIZABETH THOMPSON

Teen women: disparity between cognitive values and anticipated life events
Child Welfare, March/April 1984, 63(2), 125-138

Data from a study of teen values show conflicts between values teens say they hold and their behavior. The authors try to show why this is so and suggest ways to support teens' positive values.

BOYER, SHERRY

Peer ears

Children Today, July/August 1984, 13(4), 21-23

A program at a high school in Champaign, Illinois, called Peer Ears is described. The program is run by students who have been trained to offer listening, support and alternatives to other students with problems. The focus is on talking out, not acting out. Peer Ears are not expected to solve problems but to assist students in handling their own.

DRYFOOS, JOY G.

A new strategy for preventing unintended teenage childbearing
Family Planning Perspectives, July/August 1984, 16(4), 193-195

Many high-risk teenagers are not being reached by the wide range of programs in sex and family life education, contraception, and abortion counseling and services that are available. A new approach, proposed in this article, assumes that the social and welfare needs of disadvantaged adolescents must be addressed before the need for the standard sex education and family planning services that work so well for advantaged young people.

GIBBS, JEWELLE TAYLOR

Black adolescents and youth: an endangered species
American Journal of Orthopsychiatry, January 1984 54(1), 6-21

An analysis of major social indicators shows that black youth are relatively worse off in the 1980s than they were in 1960 in rates of unemployment, delinquency, substance abuse, teenage pregnancy and suicide. Collaborative efforts among social service agencies, community organizations, and parents to develop preventive approaches to these interrelated problems are urged, and a national policy for children and families is called for.

MANNING, M. LEE

Three myths concerning adolescence
Adolescence, Winter 1983, 18(72), 823-829

This paper examines relevant literature from the seventeenth century to the present regarding myths about adolescence. The findings do not support the following three contentions: contemporary adolescence is a time of rebellious, antisocial and unacceptable behavior; the concept of adolescence has been presented throughout history; there is a generation gap between adolescents and their parents. Belief in these myths can affect the way professionals deal with adolescents. Debunking of these myths will allow professionals who work with adolescents to maintain objectivity.

NEWMAN, JOAN

Adolescents: why they can be so obnoxious
Adolescence, Fall 1985, 20(79), 636-646

Explains that adolescents who are intelligent, reasonable and well-adjusted periodically behave in an obnoxious manner because their competencies develop unevenly. A review of teenagers' incompetencies includes examples of situations and the obnoxious behavior which results from both the incompetencies and the lack of understanding adults have of the developmental aspect of these behaviors.

MALE INVOLVEMENT

Articles

CLARK, SAMUEL D., JR., ZABIN, LAURIE and HARDY, JANET B.

Sex, contraception and parenthood: experience and attitudes among urban black young men
Family Planning Perspectives, March/April 1984, 16(2), 77-82

A study of black adolescent males attending an inner-city junior and senior high school in Baltimore revealed findings concerning experience and attitudes about sex, contraception and parenthood. The data suggest that education on the implications of early childbearing and availability of alternatives to early parenthood may be as important for such teenagers as family planning services.

ELSTER, ARTHUR B.

Teenage fathers

Medical Aspects of Human Sexuality, November 1984, 18(11), 68+

This brief guide addresses three topics regarding teenage fathers: the reasons for counseling young fathers, specific problems of teenage fathers, and how to involve young fathers in clinic services. While many of the problems teen fathers face are experienced by new fathers of any age, the teenage fathers' developmental level and their premature transition to parenthood cause unique dilemmas. The best way to reach a young father is by obtaining the cooperation of the pregnant girl.

FINKEL, MADELON LUBIN and FINKEL, DAVID J.

Male adolescent sexual behavior, the forgotten partner: a review
Journal of School Health, November 1983, 53(9), 544-547

After years of focusing attention on the female's ability and responsibility to manage her reproductive behavior, the male is finally beginning to receive notice and attention. Today, reliance on vasectomies, the condom and withdrawal account for 25 percent of the contraceptive use among couples, and trend statistics point to an increased interest among

selected populations in the use of barrier methods that require partner cooperation for effective use. The growing consensus among researchers and planners is that it is now crucial to research the adolescent male.

VAZ, ROSALIND, SMOLEN, PAUL and MILLER, CHARLENE
Adolescent pregnancy; involvement of the male partner
Journal of Adolescent Health Care, December 1983, 4(4), 246-250

The role played by the male partner in an adolescent pregnancy was investigated. Questionnaires were completed by the male partners of 41 adolescent females who continued their pregnancy to term and attended an optional education program. The male role was assessed in regard to an ongoing relationship with the mother, family involvement in the pregnancy, decision-making about the outcome of the pregnancy, involvement with a health care professional and the seeking of contraceptive information. The study indicates that the male partner is often forgotten in dealing with the pregnant adolescent. Involvement of the prospective father in the pregnancy may not only be supportive to the mother, but may have potential benefits to the child.

WILLIAM-MCCOY, JANICE E. and TYLER, FORREST B.
Selected psychosocial characteristics of black unwed adolescent fathers
Journal of Adolescent Health Care, January 1985, 6(1), 12-16

Adolescent fathers and nonfathers were compared as to their belief in a sense of personal control and responsibility for their own lives; ability to optimistically trust others; taking an active orientation to life's demands and problems; and family. Results suggest that adolescent fathers are usually older, more likely to have been born out-of-wedlock, and less trusting than nonfathers. The implications for casework with adolescent fathers are discussed.